DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 418 and 424

[CMS–1787–F]

RIN 0938–AV10

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule updates the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year (FY) 2024. This rule discusses the comments received regarding information related to the provision of higher levels of hospice care; spending patterns for non-hospice services provided during the election of the hospice benefit; ownership transparency; equipping patients and caregivers with information to inform hospice selection; and ways to examine health equity under the hospice benefit. This rule also finalizes conforming regulations text changes related to the expiration of the COVID–19 public health emergency. In addition, this rule updates the Hospice Quality Reporting Program; discusses the Hospice Outcomes and Patient Evaluation tool; provides an update on Health Equity and future quality measures; and provides updates on the Consumer Assessment of Healthcare Providers and Systems, Hospice Survey Mode Experiment. This rule also codifies hospice data submission thresholds and discusses updates to hospice survey and enforcement procedures. Additionally, the rule requires hospice certifying physicians to be Medicare-enrolled or to have validly opted-out.

DATES: These regulations are effective on October 1, 2023. The implementation date for the provider enrollment provisions in this final rule is May 1, 2024.

FOR FURTHER INFORMATION CONTACT: For general questions about hospice payment policy, send your inquiry via email to: *hospicepolicy@cms.hhs.gov.*

For questions regarding the CAHPS® Hospice Survey, contact Lauren Fuentes at (410) 786–2290.

For questions regarding the hospice conditions of participation (CoPs), contact Mary Rossi-Coajou at (410) 786–6051.

For questions regarding the hospice public reporting, contact Charles Padgett at (410) 786–2811.

For questions regarding the hospice quality reporting program, contact Jermama Keys at (410) 786–7778.

For questions regarding hospice certifying physician provider enrollment, contact Frank Whelan at (410) 786–1302.

For information regarding the hospice special focus program, send your inquiry via email to *QSOG_hospice@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose

This final rule updates the hospice wage index, payment rates, and cap amount for Fiscal Year (FY) 2024 as required under section 1814(i) of the Social Security Act (the Act). This rule discusses the comments received regarding information related to the provision of higher levels of hospice care; spending patterns for non-hospice services provided during the election of the hospice benefit; ownership transparency; equipping patients and caregivers with information to inform hospice selection; and ways to examine health equity under the hospice benefit and finalizes regulations text changes to align with the expiration of the COVID–19 public health emergency (PHE). This final rule also discusses updates to the Hospice Quality Reporting Program (HQRP) and the further development of the Hospice Outcomes and Patient Evaluation (HOPE) tool with national beta test analyses; and discusses updates on Health Equity and future quality measures (QMs). It also provides updates on the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Hospice Survey Mode Experiment. This rule codifies hospice data submission thresholds and discusses updates to hospice survey and enforcement procedures.

In addition, this final rule finalizes provider enrollment requirements for certifying physicians for hospice services. This rule also finalizes text changes to regulations that align with the expiration of the COVID–19 PHE.

B. Summary of the Major Provisions

In section III.A of this final rule, we discuss the comments received related to the following: increasing access to higher levels of hospice care; our analysis of non-hospice spending during a hospice election; ownership transparency; hospice election decision-making; and ways to examine health equity under the hospice benefit.

In section III.B of this rule, we finalize the FY 2024 hospice payment update percentage of 3.1 percent, update the hospice payment rates and the hospice cap amount for FY 2024 by the hospice payment update percentage of 3.1 percent. We also discuss the finalized text changes to the regulations related to the expiration of the COVID–19 PHE.

In section III.C of this final rule, we update the HQRP including the HOPE tool and update the Health Equity and future quality measures; update the CAHPS® Hospice Survey Mode Experiment; and finalize our proposal to codify the hospice data submission threshold.

In section III.D of this final rule, we update the hospice survey and enforcement procedures.

Finally, in section III.E of this final rule, we discuss our requirement that physicians who certify hospice services for Medicare beneficiaries be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question.

C. Summary of Impacts

The overall economic impact of this final rule is estimated to be $780 million in increased payments to hospices in FY 2024.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of a terminally ill individual and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define ''palliative care'' as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (§ 418.3). Palliative care is at the core of hospice philosophy and care practices and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological,

emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice is compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient's attending physician (if any) and the hospice medical director must certify that the individual is ''terminally ill,'' as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. The regulations at § 418.22(b)(2) require that clinical information and other documentation that support the medical prognosis accompany the certification and be filed in the medical record with it and regulations at § 418.22(b)(3) require that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Under the Medicare hospice benefit, the election of hospice care is a patient choice and once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group is essential in the seamless provision of primarily home-based services. The hospice interdisciplinary group works with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary's care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

If, in the judgment of the hospice interdisciplinary group, which includes the hospice physician, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to their home and continue to receive routine home care. Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. CHC may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with the regulations at § 418.204. A minimum of 8 hours of nursing care or nursing and aide care must be furnished on a particular day to qualify for the CHC rate (§ 418.302(e)(4)).

Hospices covered by this rule must comply with applicable civil rights laws, including section 1557 of the Affordable Care Act, section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, which require covered programs to take appropriate steps to ensure effective communication with patients with disabilities and patient companions with disabilities, including the provisions of auxiliary aids and services when necessary for effective communication.[1] Further information may be found at: *http://www.hhs.gov/ocr/civilrights.*

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin in federally assisted programs or activities. This includes a requirement that recipients of Federal financial assistance take reasonable steps to provide meaningful access to their programs or activities to individuals with limited English proficiency (LEP) (Lau v. Nichols, 414 U.S. 563 (1974)). Similarly, Section 1557's implementing regulation requires covered entities to take reasonable steps to provide meaningful access to LEP individuals in federally funded health programs and activities (45 CFR 92.101(a)). Meaningful access may require the provision of services and translated materials (45 CFR 92.101(a)(2)).

B. Services Covered by the Medicare Hospice Benefit

Coverage under the Medicare hospice benefit requires that hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. Section 1861(dd)(1) of the Act establishes the services that are to be rendered by a Medicare-certified hospice program. These covered services include: nursing care; physical therapy; occupational therapy; speech-language pathology therapy; medical social services; home health aide services (called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologicals); medical appliances; counseling services (including dietary counseling); short-term inpatient care in a hospital, nursing facility, or hospice inpatient facility (including both respite care and procedures necessary for pain control and acute or chronic symptom management); continuous home care during periods of crisis, and only as necessary, to maintain the terminally ill individual at home; and any other item or service which is specified in the plan of care and for which payment may otherwise be made under Medicare, in accordance with Title XVIII of the Act.

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary, who is a hospice patient, be established before care is provided by, or under arrangements made by, the hospice program; and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act).

Upon the implementation of the hospice benefit, the Congress also expected hospices to continue to use volunteer services, although Medicare does not pay for these volunteer services (section 1861(dd)(2)(E) of the Act). As stated in the Health Care Financing Administration's (now Centers for Medicare & Medicaid Services (CMS)) proposed rule ''Medicare Program; Hospice Care (48 FR 38149), the hospice must have an interdisciplinary group composed of paid hospice employees as well as hospice volunteers, and that ''the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices.'' This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end of life care.

C. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and the regulations in 42 CFR part

[1] Hospices receiving Medicare Part A funds or other federal financial assistance from the Department are also subject to additional federal civil rights laws, including the Age Discrimination Act, and are subject to conscience and religious freedom laws where applicable.

418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment based on one of four prospectively determined rate categories of hospice care (RHC, CHC, IRC, and GIP), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected the benefit). This per diem payment is meant to cover all hospice services and items needed to manage the beneficiary's care, as required by section 1861(dd) (1) of the Act.

While payment made to hospices is to cover all items, services, and drugs for the palliation and management of the terminal illness and related conditions, federal funds cannot be used for prohibited activities, even in the context of a per diem payment. While a recent article in a policy journal [2] discussed the potential role hospices could play in medical aid in dying (MAID) where such practices have been legalized in certain states, the Assisted Suicide Funding Restriction Act of 1997 (Pub. L. 105–12, April 30, 1997) prohibits the use of federal funds to provide or pay for any health care item or service or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual including ''mercy killing, euthanasia, or assisted suicide''. However, the prohibition does not pertain to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing or accelerating death.

The Medicare hospice benefit had been revised and refined since its implementation after various Acts of Congress and Medicare rules. For a historical list of changes and regulatory actions, we refer readers to the background section of previous Hospice Wage Index and Payment Rate Update rules.[3]

III. Provisions of the Final Rule

A. Hospice Utilization and Spending Patterns

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20022), CMS provided data analysis on hospice utilization trends from FY 2013 through FY 2022. The analysis included data on the number of beneficiaries using the hospice benefit, live discharges, reported diagnoses on hospice claims, Medicare hospice spending, Parts A, B and D non-hospice spending during a hospice election, as well as services used outside of the hospice benefit while a patient is under a hospice election. The proposed rule solicited comments from the public, hospice providers, patients, and advocates regarding utilization of, and barriers to higher levels of hospice care and complex palliative treatments; our analysis of non-hospice spending during a hospice election; ownership transparency; and hospice election decision making. Additionally, we solicited comments on ways to examine health equity under the hospice benefit. Several commenters thanked CMS for continuing to incorporate monitoring and data analysis into its proposed hospice payment rule.

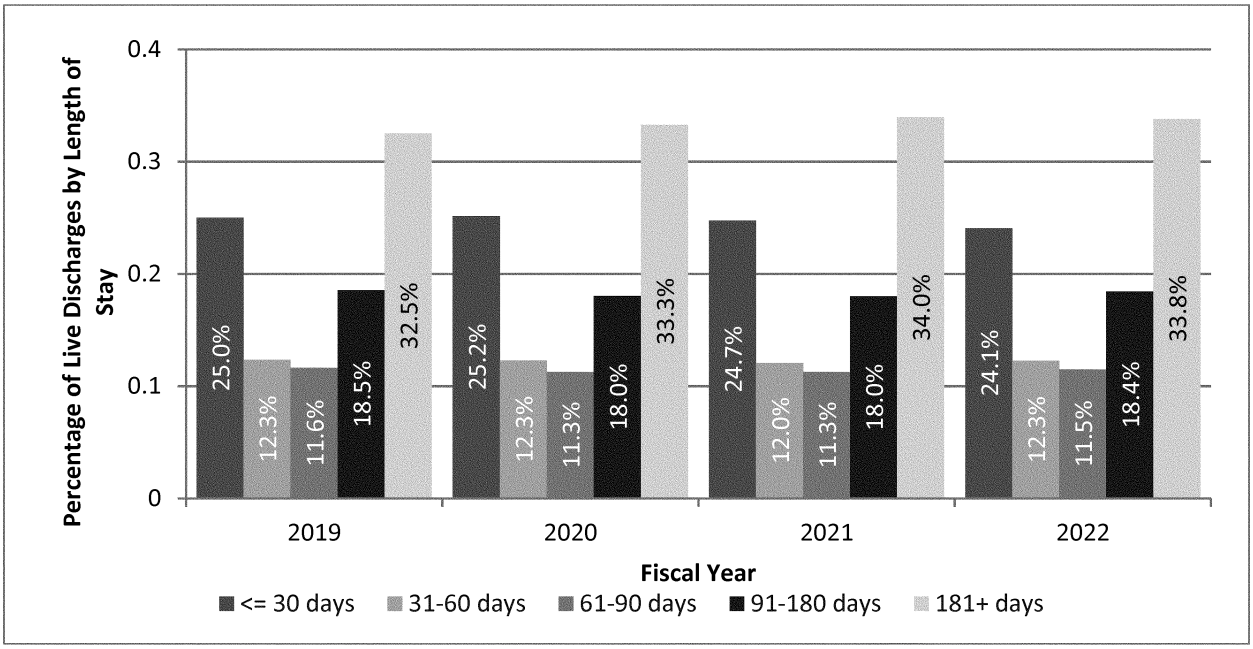
1. Correction to Figure 3 in the FY 2024 Hospice Proposed Rule

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20032), we 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:

[2] Nelson, R., Should Medical Aid in Dying Be Part of Hospice Care? Medscape Nurses. February 26, 2020. *https://www.medscape.com/viewarticle/925769#vp_1.*

[3] Hospice Regulations and Notices. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices.*

Figure 3: Length of Stay Intervals Distribution for Live Discharges, FYs 2019 to 2022



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.

2. Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making

As we continue to focus on improved access and value within the hospice benefit, in the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20022), we solicited comments from the public, including hospice providers as well as patients and advocates, regarding certain notable trends in the analysis that coincide with hospice misinformation obtained anecdotally from beneficiaries; that is, information related to the provision of higher levels of hospice care (specifically, CHC, IRC, and GIP) and procedures (specifically, chemotherapy/radiation, blood transfusions, or dialysis) administered for palliation when a patient is under a hospice election. We queried interested parties on potentially restrictive admission policies for beneficiaries requiring higher-intensity end-of-life and/or palliative care, the frequency and modality in which hospices educate themselves on the distinction between curative and complex palliative treatments, and the way they communicate this information to patients throughout the hospice election. We solicited comments specifically on how hospices address financial risks associated with providing such services, overcome barriers to providing higher intensity levels of hospice care and complex palliative treatments, and provide necessary information to patients and families about coverage, staffing levels, staff encounters, and utilization of higher levels of care. We asked for feedback on how CMS can work with hospice providers to ensure Medicare beneficiaries and their families are aware of the coverage under the hospice benefit and how we can enhance transparency in ownership trends for beneficiaries selecting hospice care. More generally, we solicited comments on how CMS can assist hospices in better serving vulnerable and underserved populations and address barriers to access.

In total, we received 39 comments in response to our request for information on hospice utilization, non-hospice spending, ownership transparency, and hospice election decision-making. These comments and our responses are summarized in this section of the rule.

Comment: Commenters expressed general concerns about potential admission policies that could restrict access to higher cost end-of-life palliative care and discussed inconsistencies in beneficiary access to treatments that may be based on specific hospice policy or disease states. They emphasized the need for definitive instruction and clear expectations from CMS regarding expectations of hospice providers in determining curative versus palliative treatment coverage under the hospice benefit. Respondents stated that in providing this additional guidance CMS should be mindful of the importance of individual hospice policies; however, education and clear guidance from CMS is crucial in avoiding confusion as to what treatments can be provided under the hospice benefit.

Commenters also identified general challenges that could lead to barriers to providing higher levels of hospice care, such as limited bed capacity in skilled nursing facilities, difficulties in obtaining and maintaining contracts with inpatient facilities, staffing challenges/volunteer shortages, and restrictive rules on the provision of GIP and CHC. Recommendations included exploring options for in-home respite care, extending the duration of inpatient respite care, and providing CHC during

the actively dying phase to improve patient care and reduce unnecessary hospitalizations, as it was noted that current policy guidance is not clear as to whether it is permissible to provide GIP and/or CHC only during periods of active crisis or if it could be provided during the entirety of the ''active dying'' phase.

Commenters also highlighted increased costs associated with providing complex palliative treatments and higher intensity levels of hospice care and they stated that these costs may pose financial risks to hospices when enrolling such patients. Respondents strongly suggested exploring flexibilities or additional payments (recommendations included the implementation of a risk adjusted, add-on and/or outlier payment models) to ensure appropriate payment and timely hospice admission. Several commenters requested that CMS address the potential correlation between costs and financial risks associated with providing complex palliative treatments (that is, chemotherapy/radiation, blood transfusions or dialysis), stating that the current bundled per diem payment is not reflective of the increased expenses associated with higher-cost and outlier patient subgroups.

Commenters emphasized the need for CMS education directed towards patients and families about transitioning from curative interventions to palliative interventions at the time of hospice admission. Specifically, a few commenters suggested that the Patient Notification of Hospice Non-Covered Items, Services, and Drugs should be provided to all prospective patients at the time of hospice election or as part of the care plan. Commenters suggestions also included clarifying coverage for procedures related to the primary diagnosis and exploring the use of Advanced Beneficiary Notices (ABNs). Commenters noted that hospice providers, non-hospice providers, Medicare beneficiaries, and their families need more information to understand these distinctions and that hospice providers must share the information with patients at the time of election and throughout the hospice election. However, to the contrary, several other interested parties raised concerns about administrative burden regarding the provision of more information during a period in which beneficiaries and their families are overwhelmed and that such education may not serve its intended purpose.

Commenters raised concerns about the growth of non-hospice spending for beneficiaries who elect hospice, particularly with those hospice agencies who intentionally focus on long-term, low-cost patients, as the analysis included in the proposed rule highlighted these spending patterns. Respondents discussed potential policies beyond prior authorization and the hospice election statement addendum, to ensure appropriate coverage of prescription drugs and services related to terminal illnesses and related conditions for hospice patients. They suggested the need for additional coordination and communication between hospices, providers, and Part D plans to streamline the coverage process and ensure timely access to necessary medications and services.

Regarding CMS' inquiry on how to increase transparency to promote informed decision-making when choosing a hospice, respondents recommended providing public information about hospice staffing levels, frequency of hospice staff encounters, and utilization of higher levels of care. They suggested including this information on Medicare's Care Compare website or other accessible platforms to ensure transparency and facilitate informed decision-making. They also suggested CMS improve transparency around ownership trends and provide information about hospice ownership publicly, as ultimately, this information would be helpful for beneficiaries seeking to select a hospice for end-of-life care. Respondents recommended differentiating between nonprofit and for-profit hospices and examining ownership trends.

Response: We appreciate the comments and suggestions received regarding hospice utilization, non-hospice spending, ownership transparency, and hospice election decision-making. We acknowledge commenters' statements and concerns related to the increase in non-hospice spending, barriers associated with the provision of GIP, IRC, CHC and complex palliative procedures (such as chemotherapy/radiation, blood transfusions, or dialysis) under the hospice election, as well as the financial risks associated with providing these services.

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), we 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).

Overall, the insights and suggestions provided by all respondents will help inform our policy-making measures and will aid our efforts of continuous improvements to hospice policies to ensure better access and quality of care for Medicare beneficiaries. We intend to consider all comments and suggestions to potentially enhance policy development, address barriers, and promote transparency under the hospice benefit for potential future rulemaking.

3. RFI on Health Equity Under the Hospice Benefit

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20022), CMS solicited comments from interested parties on health equity under the hospice benefit. The proposed rule also solicited comments from the public, hospice providers, patients, and advocates regarding how hospices are measuring impact on health equity, barriers in electing and accessing hospice care, and challenges faced by hospices in collecting and analyzing information related to social determinants of health (SDOH). We also solicited comments on what data should be collected to evaluate health equity, geographical area indices that can be used to assess disparities in hospice, and how CMS can collect and share information to help hospices serve vulnerable and underserved populations and address barriers to access.

We received 20 comments in response to our request for information on health equity under the hospice benefit. The following is a summary of these comments:

Comment: Commenters described the various barriers and challenges in collecting information on SDOH and health equity data, such as patient resistance, difficulty in appropriately

recording SDOH using electronic medical records (EMR), lack of specificity in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaires provided to patients' families, and limited resources for data collection. One commenter suggested that CMS should change the terminology used from ''health equity'' to ''healthcare equity'' to capture what can be measured in terms of processes of care or outcomes of care. Commenters also noted their efforts to employ and recruit diverse staff to better represent and serve underserved populations, in addition to holding trainings to address any barriers patients may experience related to SDOH. Commenters provided recommendations for CMS to consider, such as developing educational tools about cultural norms to facilitate discussions about hospice care, and implementing a nationally recognized, standardized, and required assessment tool with data elements collecting SDOH data. They suggested examples of SDOH data that should be collected that included health literacy, race, ethnicity and language data, sexual orientation and gender identity data, housing security, air and water pollution, food security, living in heat islands, and access to health care. One commenter also suggested that any health equity data elements should be exempt from the Hospice Quality Reporting Program (HQRP) data completion threshold due to the sensitivity and potential communication issues present at end of life. Several commenters also recommended the development of a universal database accessible across the government to enable programs to accurately assess the extent of the disparities and barriers existing today and to measure progress made by hospice in promoting health equity over time.

Response: We appreciate the comments provided in response to our request for information regarding health equity under the hospice benefit. We plan to consider these comments and suggestions for potential future rulemaking as we explore all opportunities to collect and measure data impacting health equity, examine barriers in electing and accessing hospice care, assess disparities in the provision of care, and improve how CMS can help hospices serve vulnerable and underserved populations. Public input is very valuable for the continuing development of CMS' health equity efforts and broader commitment to health equity; a key pillar of our strategic vision as further described here, *https://www.cms.gov/files/document/health-equity-fact-sheet.pdf.*

B. FY 2024 Hospice Wage Index and Rate Update

1. FY 2024 Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospices under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished. The hospice wage index utilizes the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Our regulations at § 418.306(c) require each labor market to be established using the most current hospital wage data available, including any changes made by the Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions.

In general, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On March 6, 2020, OMB issued Bulletin No. 20–01, which provided updates to and superseded OMB Bulletin No. 18–04 that was issued on September 14, 2018. The attachments to OMB Bulletin No. 20–01 provided detailed information on the update to statistical areas since September 14, 2018, and were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2017, and July 1, 2018. For a copy of this bulletin, we refer readers to the following website: *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf.* In OMB Bulletin No. 20–01, OMB announced one new Micropolitan Statistical Area, one new component of an existing Combined Statistical Area (CSA), and changes to New England City and Town Area (NECTA) delineations. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we stated that if appropriate, we would propose any updates from OMB Bulletin No. 20–01 in future rulemaking. After reviewing OMB Bulletin No. 20–01, we determined that the changes in Bulletin 20–01 encompassed delineation changes that would not affect the Medicare wage index for FY 2022. Specifically, the updates consisted of changes to NECTA delineations and the redesignation of a single rural county into a newly created Micropolitan Statistical Area. The Medicare wage index does not utilize NECTA definitions, and, as most recently discussed in the FY 2021 Hospice Wage Index final rule (85 FR 47070), we include hospitals located in Micropolitan Statistical areas in each state's rural wage index.

In the FY 2020 Hospice Wage Index final rule (84 FR 38484), we finalized the proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we adopted the revised OMB delineations with a 5-percent cap on wage index decreases, where the estimated reduction in a geographic area's wage index would be capped at 5 percent in FY 2021 and no cap would be applied to wage index decreases for the second year (FY 2022). In the FY 2023 Hospice Wage Index final rule (87 FR 45673), we finalized for FY 2023 and subsequent years, the application of a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline, so that a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY.

For FY 2024, the final hospice wage index is based on the FY 2024 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2019 and before October 1, 2020 (FY 2020 cost report data). The final FY 2024 hospice wage index does not take into account any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The final FY 2024 hospice wage index includes a 5-percent cap on wage index decreases. The appropriate wage index value would be 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. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all the core-based statistical areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2024, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia

and the wage index value for Hinesville-Fort Stewart, Georgia is 0.8732.

To address rural areas where there were no hospitals, and thus no hospital wage data on which to base the calculation of the hospice wage index, in the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area without rural hospital wage data, we would use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term ''contiguous'' means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity of almost all of Puerto Rico's various urban areas to non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2024, we proposed to continue using the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. As previously discussed, the pre-floor, pre-reclassified hospital wage index values below 0.8 would be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15, which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

The final hospice wage index applicable for FY 2024 (October 1, 2023 through September 30, 2024) is available on the CMS website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.*

We received 15 comments on the proposed FY 2024 hospice wage index from various stakeholders, including hospices and national industry associations. A summary of these comments and our responses to those comments are as follows:

Comment: A few commenters expressed concern with the CBSA designations and wage index values assigned to their geographic areas. Several commenters representing hospices in Coeur d'Alene, ID stated that the economy and cost-of-living of Coeur d'Alene, ID is not reflective of the rest of the Idaho region, but rather is reflective of the ''Pacific'' region that includes the Spokane, WA CBSA. These commenters recommended that Coeur d'Alene, ID be reassigned to the Spokane, WA CBSA and assigned the wage index value of that CBSA. Another commenter stated that hospices in Montgomery County, MD should be paid the same as hospices in the Washington, DC area because Montgomery County, MD has a similar cost of living as Washington, DC and shares the same labor market when competing for labor. This commenter recommended that the wage index for the Montgomery County/Fredrick, MD CBSA be reassigned to the Washington, DC CBSA or be assigned the highest wage index valuation from among the MSAs metropolitan divisions for the purpose of hospice Medicare payment for a time limited period, such as five years, in order to evaluate the impact on Montgomery County hospices.

Response: We thank the commenters for these recommendations. However, we have used CBSAs for determining hospice payments since FY 2006 and continue to believe that the OMB's geographic area delineations represent a useful proxy for differentiating between labor markets and that the geographic area delineations are appropriate for use in determining Medicare hospice payments. CBSAs provide a uniform and consistent basis for determining statistical area delineations, based on long-standing statistical standards maintained by OMB. Further, OMB conducts periodic review of the standards to ensure their continued usefulness and relevance. Additionally, other provider types, such as Inpatient Prospective Payment System (IPPS) hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and dialysis facilities, all use CBSAs to define their labor market areas. Therefore, we believe it is important to apply this method consistently among providers. Using the most current OMB delineations provides an accurate representation of geographic variation in wage levels; therefore, we do not believe it would be appropriate to allow hospices in Coeur d'Alene, ID or Montgomery County, MD to be reassigned into a higher CBSA designation. However, if OMB redesignates Coeur d'Alene, ID or Montgomery County, MD into the Spokane, WA or the Washington, DC CBSAs (respectively), we would propose this change in future rulemaking consistent with our longstanding approach of adopting OMB statistical area delineations outlined in the most recent OMB bulletins.

Comment: A few commenters expressed concern that the wage index values assigned to rural areas negatively impacts rural hospice care. One commenter stated that hospices that serve rural patients receiving services in their homes are subject to a trend of reduced wage index values, creating a continued reduction in their Medicare rates as compared to the national average. Another commenter recommended that CMS assign the wage index value based on a hospice's office location rather than the beneficiary's location. This commenter suggested that it costs more for their hospice to serve rural areas due to the great distance they are required to travel despite being paid at only 80 percent of the wage index.

Response: We thank the commenters for their recommendations. We understand there are variables in providing care that are unique to both urban and rural areas. For instance, rural hospices note higher mileage costs between patients, while urban hospices note additional costs associated with necessary security measures and traffic congestion. However, these factors do not result in lower hospice wage index values in rural areas versus urban areas. The hospice wage index reflects the wages that inpatient hospitals pay in their local geographic areas. Regarding the recommendation to assign the wage index value based on the location of the hospice's office, we continue to believe that is more appropriate to assign the wage index value based on the site of service (the location of the beneficiary) rather than the hospice's office location. Therefore, we apply the wage index value 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.

Comment: Several commenters recommended more far-reaching revisions and reforms to the wage index methodology used under Medicare fee-for-service. These recommendations included: geographic reclassification, implementing an out-migration adjustment for non-hospital providers using the post floor- post reclassified IPPS wage index as the basis for the hospice wage index, and reinstituting the rural floor policy so that no hospice is paid below the rural floor for their state. Another commenter recommended CMS explore policies that seek to reduce the continual wage index disparities between high wage index hospices and low wage index hospices such as has been done in the hospital space. Finally, MedPAC recommended that Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that: use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type; reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and smooth wage index differences across adjacent local areas.

Response: We appreciate the commenters' recommendations; however, these comments are outside the scope of the proposed rule. Any changes regarding the adjustment of the hospice payments to account for geographic wage differences, beyond the wage index proposals discussed in the FY 2024 Hospice Wage Index and Rate Update proposed rule, would have to go through notice and comment rulemaking. While CMS and other interested parties, such as MedPAC, have explored potential alternatives to the current CBSA-based labor market system, no consensus has been achieved regarding how best to implement a replacement system. we believe that in the absence of hospice specific wage data, using the pre-floor, pre-reclassified hospital wage data is appropriate and reasonable for hospice payments. Additionally, the regulations that govern hospice payment do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor provisions that exist for IPPS hospitals. The reclassification provision found in section 1886(d)(10) of the Act is specific to hospitals. Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33) provides that the area wage index applicable to any hospital that is located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas in that state. This rural floor provision is also specific to hospitals. Because the reclassification provision and the hospital rural floor applies only to hospitals, and not to hospices, we continue to believe the use of the pre-floor and pre-reclassified hospital wage index results is the most appropriate adjustment to the labor portion of the hospice payment rates. This position is longstanding and consistent with other Medicare payment systems (for example, SNF PPS, IRF PPS, and HH PPS). However, the hospice wage index does include the hospice floor, which is applicable to all CBSAs, both rural and urban. The hospice floor adjusts pre-floor, pre-reclassified hospital wage index values below 0.8 by a 15 percent increase subject to a maximum wage index value of 0.8.

Comment: One commenter recommended lowering the permanent 5-percent cap on wage index decreases to a 3-percent cap to protect hospice providers who are already operating with negative or razor-thin operating margins.

Response: We thank the commenter for their recommendation. However, this is outside the scope of the proposed rule. The policy to apply a permanent 5-percent cap on wage index decreases was finalized in the FY 2023 hospice final rule (87 FR 45677). Any changes to the permanent cap policy would have to be proposed and finalized through the rulemaking process and we have not proposed to make any changes to the cap policy for the upcoming fiscal year.

Final Decision: We are finalizing our proposal to use the FY 2024 pre-floor, pre-reclassified hospital wage index data as the basis for the FY 2024 hospice wage index. The wage index applicable for FY 2024 is available on our website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.* The hospice wage index for FY 2024 is effective October 1, 2023 through September 30, 2024.

2. FY 2024 Hospice Payment Update Percentage

Section 4441(a) of the BBA (Pub. L. 105–33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient hospital market basket percentage increase for that FY. In the FY 2022 IPPS final rule we finalized the rebased and revised IPPS market basket to reflect a 2018 base year. We refer readers to the FY 2022 IPPS final rule (86 FR 45194 through 45208) for further information.

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment''). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the United States economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term ''multifactor productivity'' with ''total factor productivity'' (TFP). BLS noted that this is a change in terminology only and would not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as ''private nonfarm business total factor productivity.'' However, as mentioned, the data and methods are unchanged. We refer readers to *http://www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.* In addition, in the FY 2022 IPPS final rule (86 FR 45214), we noted that beginning with FY 2022, CMS changed the name of this adjustment to refer to it as the

''productivity adjustment'' rather than the ''MFP adjustment''.

In the FY 2024 Hospice Wage Index and Payment Rate Update proposed rule (88 FR 20039), we proposed to apply a market basket percentage increase of 3.0 percent for FY 2024 using the most current estimate of the inpatient hospital market basket (based on IHS Global Inc.'s fourth quarter 2022 forecast with historical data through the third quarter of 2022). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the proposed inpatient hospital market basket percentage increase for FY 2024 of 3.0 percent is required to be reduced by a productivity adjustment as mandated by the Affordable Care Act (estimated in the proposed rule to be 0.2 percentage point for FY 2024). Therefore, the proposed hospice payment update percentage for FY 2024 was 2.8 percent. We stated that if more recent data became available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the inpatient hospital market basket update or productivity adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage for FY 2024 in the final rule. For this final rule, based on IHS Global Inc.'s (IGI) second quarter 2023 forecast with historical data through the first quarter of 2023, the inpatient hospital market basket percentage increase for FY 2024 is 3.3 percent. The forecast of the productivity adjustment for FY 2024 for this final rule, based on IGI's second quarter 2023 forecast, is 0.2 percent. Therefore, the hospice payment update percentage for FY 2024, based on more recent data, is 3.1 percent.

We continue to believe it is appropriate to routinely update the hospice payment system so that it reflects the best available data about differences in patient resource use and costs among hospices as required by the statute. Therefore, we are updating hospice payments using the methodology outlined and apply the 2018-based IPPS market basket percentage increase for FY 2024 of 3.3 percent, reduced by the statutorily required productivity adjustment of 0.2 percentage point along with the wage index budget neutrality adjustment to update the payment rates. We are using the FY 2024 hospice wage index, which uses the FY 2024 pre-floor, pre-reclassified IPPS hospital wage index as its basis.

In the FY 2022 Hospice Wage Index final rule (86 FR 42532 through 42539), we rebased and revised the labor shares for RHC, CHC, GIP, and IRC using MCR data for freestanding hospices (CMS Form 1984–14, OMB Control Number 0938–0758) from 2018. The current labor portion of the payment rates are: RHC, 66.0 percent; CHC, 75.2 percent; GIP, 63.5 percent; and IRC, 61.0 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. The non-labor portion of the payment rates are as follows: RHC, 34.0 percent; CHC, 24.8 percent; GIP, 36.5 percent; and IRC, 39.0 percent.

We received 40 comments on the proposed hospice update percentage of 2.8 percent. A summary of the comments and our responses to those comments are as follows:

Comment: Two commenters, including MedPAC, expressed support for the proposed payment update percentage. MedPAC, stated that they believe the statutorily required market basket payment update for FY 2024 is adequate for hospice payments. The Commission stated that the March 2023 MedPAC report found that indicators of payment adequacy for hospices—including beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers' costs—are generally positive. In particular, the report found that 2020 Medicare margins were 14.2 percent and projected 2023 Medicare margins to be around 8 percent.

Response: We thank commenters for their support.

Comment: Many commenters expressed appreciation for the proposed 2.8 percent increase to hospice payment rates, yet also expressed concern that the proposed update is inadequate. These commenters highlighted that they have experienced unprecedented wage and inflationary pressures over the last several years. They stated that wage costs reflect the majority of expenses and in order to recruit and retain staff they have had to dramatically increase salary and benefit costs as well as rely on more contract labor. They also state that inflation for other goods and services, such as drugs and medical supplies, have contributed to a significant increase in operating costs. Some commenters stated that increased transportation costs, like gasoline prices, have a disproportionate impact on hospice providers, particularly those serving rural patients.

Response: We appreciate the support for the statutorily required hospice payment update, and understand commenter concerns; however, as directed by section 1814(i)(1)(C)(ii)(VII) of the Act, we are required to update hospice payments by the Inpatient Hospital PPS (IPPS) market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year, adjusted for productivity (as required by section 1814(i)(1)(C)(iv)(I) of the Act). Section 1886(b)(3)(B)(iii) of the Act defines the market basket percentage increase to be based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services. The 2018-based IPPS market basket is a fixed-weight, Laspeyres-type index that measures price changes over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services. As such, the inpatient hospital market basket percentage increase would reflect the prospective price pressures described by the commenters during a high inflation period (such as faster wage growth or higher energy prices) but might not reflect other factors that could increase costs such as the quantity of labor used or any shifts between contract and staff nurses. We note that cost changes (that is, the product of price and quantities) would only be reflected when a market basket is rebased, and the base year weights are updated to a more recent time period.

We agree with the commenters that recent higher inflationary trends have impacted the outlook for price growth over the next several quarters. At the time of the FY 2024 Hospice proposed rule, based on IGI's fourth quarter 2022 forecast with historical data through the third quarter of 2022, the 2018-based inpatient hospital market basket percentage increase was forecasted to be 3.0 percent for FY 2024 reflecting a 3.9-percent forecasted compensation price increase. As stated, in the FY 2024 Hospice proposed rule, we proposed that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2024 inpatient hospital market basket update for the final rule. For this final rule, we are using an updated forecast of the price proxies underlying the market basket that incorporates more recent historical data and reflects a revised outlook regarding the U.S. economy, including compensation and inflationary pressures. As stated previously, based on IGI's second quarter 2023 forecast with historical data through first quarter 2023, the FY 2024 inpatient hospital market basket percentage increase is 3.3 percent (reflecting forecasted compensation price growth of 4.3 percent) and the FY 2024 productivity adjustment is 0.2 percentage point. After consideration of

the comments received, for FY 2024, the final hospice payment update is 3.1 percent (3.3 percent inpatient hospital market basket percentage increase less a 0.2 percentage point productivity adjustment), compared to the proposed hospice payment update for FY 2024 of 2.8 percent.

Comment: Several commenters stated that the IPPS market basket reflects a 2018 base year and while more recent final data may not yet be available, it should be clear that providers' cost structures have changed since 2018. Commenters were also concerned that the lag in the cost reporting and other structures and/or indexes that are used as inputs in determining hospice payment in this proposed rule fail to capture the inflationary pressures that providers must bear to provide care in real time and request that CMS consider this fact for the final rule.

Response: The IPPS market basket measures price changes (including changes in the prices for wages and salaries) over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services until the market basket is rebased. We appreciate the commenter's request to rebase the IPPS market basket more frequently. Section 404 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) states the Secretary shall establish a frequency for revising the cost weights of the IPPS market basket more frequently than once every 5 years. We established a rebasing frequency of every four years, in part because the cost weights obtained from the Medicare cost reports do not indicate much of a change in the weights from year to year. The most recent rebasing of the IPPS market basket was for the FY 2022 payment update (86 FR 45194 through 45207) and reflected a base year of 2018 costs. Despite this established frequency, we regularly monitor the Medicare cost report data to assess whether a rebasing is technically appropriate, and we will continue to do so in the future. In this Medicare report we share some preliminary analysis of the Medicare cost report data for IPPS hospitals for 2021 that became available for this final rule. For 2021, the IPPS compensation cost weight is estimated to be about 1 percentage point lower than the 2018-based IPPS market basket compensation cost weight of 53.0 percent and reflects a combined decrease in the salary and benefit cost weights that is larger than the increase in the contract labor cost weight. The major cost categories that preliminarily show an increase in the cost weight over this period are pharmaceuticals (proxied by the PPI—Commodity—Special Index—Pharmaceuticals for human use, prescription) and home office contract labor compensation costs (which, would be proxied by the ECI for Professional and Related workers). We plan to review the 2021 Medicare cost report data in more detail as well as 2022 Medicare cost report data as soon as complete information is available and evaluate these data for future rebasing of the IPPS market basket.

Comment: Many commenters stated that the unprecedented magnitude of the market basket forecast error over 2021 and 2022 warrants special consideration to avoid significant long-term underfunding of the hospice benefit and to help address current workforce challenges. Several commenters noted that in FY 2021 and FY 2022, CMS forecasted 2.4 percent and 2.7 percent cost inflation while the commenters stated that the actual cost inflation borne by hospice providers was 3.1 percent and 5.7 percent respectively, which the commenters calculated to be a 3.7 percent payment update error. Commenters requested that CMS use the special exceptions and adjustments authority to apply a one-time cumulative retrospective adjustment of 3.7 percent for FYs 2021 and 2022 to ensure that Medicare payments more accurately reflect the cost of providing hospice care. The commenters highlighted that the law does not prohibit CMS from adjusting the annual IPPS operating market basket increase (and by extension, the annual hospice rate increases) based on later known errors in historical forecasting. Several of the commenters stated that unlike other healthcare providers, such as hospitals, hospices have a large percentage (nearly 90 percent) of their revenues that originate from the Medicare program. They state that any insufficient payments from Medicare will have a more significant impact on hospice providers revenue since they do not have the ability to negotiate higher rates with private insurers.

Response: We thank the commenters for their recommendation. However, the inpatient hospital market basket percentage increases are required by law to be set prospectively, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. There is currently no mechanism to adjust for market basket forecast error in the hospice payment update. Furthermore, beginning in 1989, the Congress gave hospices their first increase (20 percent) in payment since 1986 and tied future increases to the annual increase in the hospital market basket through a provision contained in the Omnibus Budget Reconciliation Act of 1989. While the projected inpatient hospital market basket percentage increases for FY 2021 and FY 2022 were underforecast (actual increases less forecasted increases were positive), this was largely due to unanticipated inflationary and labor market pressures as the economy emerged from the COVID–19 PHE. Importantly, the hospital market basket has been used for many years to update hospice payment rates and an analysis of the forecast error over a longer period of time shows that the forecast error has been both positive and negative. For example, the 10-year cumulative forecast error (excluding FY 2018 when the hospice payment update was statutorily required to be 1.0 percent) showed a negative forecast error (that is, forecasted increases were greater than actual increases), of 0.9 percentage point (2013–2022). In addition, for each year from 2012 through 2020 (again excluding 2018), the final FY inpatient hospital market basket percentage increase (implemented in the final rule) was higher than the actual inpatient hospital market basket percentage increase once historical data were available; with 7 out of the 8 years having a forecast error greater than 0.5 percentage point (in absolute terms). Only considering the forecast error for years when the final inpatient hospital market basket percentage increase was lower than the actual inpatient hospital market basket percentage increase does not consider the numerous years that providers benefited from the forecast error.

Comment: One commenter stated concern about the quality of cost report data, especially with regard to capturing labor costs. They specifically recommend that the cost reports be amended to allow for a greater breakdown of costs for contracted versus hospice-administered inpatient services to apportion the labor share appropriately. Additionally, the commenter requested that CMS clarify how frequently they intend to update the labor shares component moving forward and clarify the development and methodology around the ''standardization factor''.

Response: While we did not solicit comments on the quality of cost report data, we appreciate the commenter's request for future changes to the hospice cost report and we will consider this comment when working on any future modifications to the hospice cost report.

Comment: A few commenters cited the resumption of the sequestration policy in 2022 as a concern regarding the adequacy of the proposed payment update percentage.

Response: We note that Medicare sequestration affects all payment systems and is not unique to the Medicare hospice benefit or the statutory authority governing the payment rate update. As such, comments regarding sequestration are outside the scope of this final rule.

Final Decision: We are finalizing the hospice payment update percentage of 3.1 percent for FY 2024. Based on IHS Global, Inc.'s more recent forecast of the inpatient hospital market basket percentage increase and the productivity adjustment, the hospice payment update percentage for FY 2024 will be 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.

3. FY 2024 Hospice Payment Rates

There are four payment categories that are distinguished by the location and intensity of the hospice services provided. The base payments are adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index. A hospice is paid the RHC rate for each day the beneficiary is enrolled in hospice, unless the hospice provides CHC, IRC, or GIP. CHC is provided during a period of patient crisis to maintain the patient at home; IRC is short-term care to allow the usual caregiver to rest and be relieved from caregiving; and GIP care is intended to treat symptoms that cannot be managed in another setting.

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 61 and beyond. In addition, in that final rule, we implemented an SIA payment for RHC when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the day of service if certain criteria are met. To maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by a service intensity add-on budget neutrality factor (SBNF). The SBNF is used to reduce the overall RHC rate in order to ensure that SIA payments are budget neutral. At the beginning of every FY, SIA utilization is compared to the prior year in order calculate a budget neutrality adjustment.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. For FY 2024 hospice rate setting, we are continuing our longstanding policy of using the most recent data available. Specifically, we are using FY 2022 claims data for the FY 2024 payment rate updates. In order to calculate the wage index standardization factor, we simulate total payments using FY 2022 hospice utilization claims data with the FY 2023 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates and compare it to our simulation of total payments using FY 2022 utilization claims data, the FY 2024 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2023 wage index and payment rates for each level of care by the FY 2024 wage index and FY 2023 payment rates, we obtain a wage index standardization factor for each level of care. The wage index standardization factors for each level of care are shown in the Tables 1 and 2.

The FY 2024 RHC rates are shown in Table 1. The FY 2024 payment rates for CHC, IRC, and GIP are shown in Table 2.

TABLE 1: FY 2024 Hospice RHC Payment Rates

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2024 Hospice Payment Update	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 Payment Rates

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	FY 2024 Hospice Payment Update	FY 2024 Payment Rates
652	**Continuous Home Care Full Rate = 24 hours of care.**	$1,522.04 ($63.42 per hour)	0.9976	1.031	$1,565.46 ($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

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 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 CY 2022 quality data. Specifically, the Act requires that, for FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket percentage increase by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. 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. These rates are shown in Tables 3 and 4.

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 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 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

We did not receive any comments on the proposed FY 2024 hospice payment rates.

Final Decision: We are finalizing the FY 2024 payment rates in accordance with statutorily mandated requirements.

4. Hospice Cap Amount for FY 2024

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014. Specifically, we stated that for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. Division CC, section 404 of the CAA, 2021 extended the accounting years impacted by the adjustment made to the hospice cap calculation until 2030. In the FY 2022 Hospice Wage Index final rule (86 FR 42539), we finalized conforming regulations text changes at § 418.309 to reflect the provisions of the CAA, 2021. Division P, section 312 of the CAA, 2022 amended section 1814(i)(2)(B) of the Act and extended the provision that mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket percentage increase reduced by the productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2031. Division FF, section 4162 of the CAA, 2023 amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket percentage increase reduced by the productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2032. Before the enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI–U beginning on October 1, 2031. Therefore, for accounting years that end after September 30, 2016 and before October 1, 2032, the hospice cap amount is updated by the hospice payment update percentage rather than the CPI–U. As a result of the changes mandated by the CAA, 2023, we are proposing conforming regulation text changes at § 418.309 to reflect the new language added to section 1814(i)(2)(B) of the Act.

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.

We received a few comments regarding the hospice cap amount. A summary of these comments and our responses to those comments are as follows:

Comment: One commenter expressed support for the FY 2024 hospice cap.

Response: We thank the commenter for their support.

Comment: A few commenters, including MedPAC, opposed an increase to the hospice cap. One commenter suggested that reducing the hospice cap level would generate savings to the hospice program and encourage all providers to focus on enhancing efforts to meet hospice eligibility and provide care for all beneficiaries. Another commenter stated that there are data that support that a lower cap results in fewer agencies exceeding it. This commenter believes that reducing the cap could decrease hospice spending by a significant amount and recommended that the cap remain at its current amount $32,486.92 with reconsideration of the cap being wage-adjusted. MedPAC recommended that the hospice aggregate cap be wage adjusted and reduced by 20 percent.

Response: We thank the commenters for their recommendations to improve the hospice cap; however, we are required by law to update the hospice cap amount from the preceding year by the hospice payment update percentage, in accordance with section 1814(i)(2)(B)(ii) of the Act. Therefore, we do not have the statutory authority to reduce the aggregate cap amount.

Final Decision: We are finalizing the update to the hospice cap amount for FY 2024 in accordance with statutorily mandated requirements.

5. Conforming Text Revisions for Telehealth Services

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20041), we proposed to revise 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. Additionally, we proposed to remove § 418.204(d), effective retroactively to May 12, 2023 to align with the end of the COVID–19 PHE. In the first COVID–19 interim final rule ''Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency'' (85 FR 19230, 19289) (April 6, 2020), we amended the hospice regulations at § 418.204 on an interim basis to specify that when a patient is receiving routine home care,

hospices could provide services via a telecommunications system, if it is feasible and appropriate 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 without jeopardizing the patients' health or the health of those who are providing such services during the COVID–19 PHE. We stated that this change was effective for the duration of the COVID–19 PHE. Specifically, we proposed to:

- 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.''
- Revise § 418.204, to remove subsection (d) to eliminate the use of technology in furnishing services during a PHE.

We received several comments regarding the regulations text revisions for telehealth services. A summary of these comments and our responses to those comments are as follows:

Comment: In general commenters appreciated the extension of the telehealth face-to-face coverage through the end of calendar year 2024. Commenters highlighted the benefits to patients and families, particularly in rural areas. Many commenters encouraged CMS to consider making this a permanent provision. Commenters cited benefits of continuing telehealth under hospice, such as helping to alleviate staffing concerns and enhanced streamlining of hospice admission.

Response: 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 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.

Comment: Some commenters encouraged CMS to develop modifiers or codes for telehealth services and require reporting on the hospice claim, similar to what was finalized in the CY 2023 HH PPS final rule, and to allow that these costs be considered allowable administrative costs on the hospice agency cost report.

Response: We will take into consideration comments requesting that supplemental telehealth contact be reported on hospice claims and as allowable administrative costs; however, 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.

Final Decision: We are finalizing the conforming regulations text revisions for telehealth as proposed.

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

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) specifies reporting requirements for the Hospice Item Set (HIS), administrative data, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. Specifically, the Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket percentage increase by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. This payment penalty increase to 4 percent is statutorily required; as discussed in the following paragraphs, we proposed to codify its application and set completeness thresholds at § 418.312(j).

Depending on the amount of the annual update for a particular year, a reduction of 4 percentage points beginning in FY 2024 could result in the annual inpatient hospital market basket percentage increase being less than zero percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the specified year. Typically, about 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.

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), we finalized two new measures using claims data: (1) Hospice Visits in the Last Days of Life (HVLDL); and (2) Hospice Care Index (HCI). We also finalized a policy that claims-based measures would use 8 quarters of data in order to publicly report on more hospices.

In addition, we removed the seven Hospice Item Set (HIS) Process Measures from the program as individual measures and public reporting because the HIS Comprehensive Assessment Measure is sufficient for measuring care at admission without the seven individual process measures. For a detailed discussion of the historical use for measure selection and removal for the HQRP quality measures, we refer readers to the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142) and the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622). In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42553), we finalized § 418.312(b)(2), which requires hospices to provide administrative data, including claims-based measures, as part of the HQRP requirements for § 418.306(b). In that same final rule, we provided CAHPS Hospice Survey updates. We finalized temporary changes to our public reporting policies based on the March 27, 2020 memorandum [4] and provided another tip sheet, referred to as the ''Third Edition HQRP Public Reporting Tip Sheet'' on the HQRP Requirements and Best Practices web page.

As finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), public reporting of the two new claims-based quality measures (QMs), the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI) is available on the Care Compare/Provider

[4] Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID–19 are available at: *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

Data Catalogue (PDC) web pages as of the August 2022 refresh. In the FY 2023 Hospice proposed rule, we did not propose any new quality measures. However, we provided updates on already-adopted measures. Table 5 shows current quality measures finalized since the FY 2022 Hospice Wage Index and Payment Rate Update final rule.

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. 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 Care 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 patient. 7. Rating of this hospice 8. Willing to recommend this hospice

2. Hospice Outcomes & Patient Evaluation (HOPE) Update

As finalized in the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), we are developing a hospice instrument named Hospice Outcomes & Patient Evaluation (HOPE). Our primary objectives for HOPE are to provide quality data for the HQRP requirements through standardized data collection; and provide additional clinical data that could inform future payment refinements. To the extent that the instrument utilizes data already being collected for the Hospice QRP, our statutory authority for the HOPE instrument derives from section 1814(i)(5)(C) of the Act. In addition, statutory language at section 1861(aa)(2)(G) of the Act permits the Secretary to impose ''such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services.''

The HOPE tool will be a component of implementing high-quality and safe hospice care for patients, both in Medicare and non-Medicare. HOPE would also contribute to the patient's plan of care through providing patient data ongoing throughout the hospice stay. By providing data from multiple time points across the hospice stay, HOPE would provide information to hospice providers to improve practice and care quality. HOPE is intended to provide quality data to calculate outcomes and develop additional quality measures.

We stated in the FY 2022 Hospice Wage Index and Payment Update final rule (86 FR 42528) that while the standardized patient assessment data elements for certain post-acute care providers required under the IMPACT Act of 2014 are not applicable to hospices, it would be reasonable to include some of those standardized elements that appropriately and feasibly apply to hospice to the extent permitted by our statutory authority. Many patients move through other providers within the healthcare system to hospice. Therefore, considering tracking key demographic and social risk factor items that apply to hospice could support our goals for continuity of care, overall patient care and well-being, development of infrastructure for the interoperability of electronic health information, and health equity which is also discussed in this rule.

In the FY 2023 Hospice Final Rule (87 FR 45669), we outlined the testing phases HOPE has undergone, including cognitive, pilot, alpha testing, and national beta field testing. National beta testing, completed at the end of October 2022, allowed us to obtain input from participating hospice teams about the assessment instrument and field testing to refine and support the final draft items and time points for HOPE. It also allowed us to estimate the time to complete the HOPE data items and establish the interrater reliability of each item.

We continue HOPE development in accordance with the Blueprint for the CMS Measures Management System. The development of HOPE is grounded in information gathering activities to identify and refine hospice domains and candidate items. We appreciate the industry's and trade associations' engagement in providing input through information sharing activities, including listening sessions, expert interviews, key stakeholder interviews, and focus groups to support HOPE development. As CMS proceeds with the refinement of HOPE, we will continue to engage with stakeholders through sub-regulatory channels. We intend to continue to host HQRP Forums to allow hospices and other interested parties to engage with us on the latest updates and ask questions on the development of HOPE and related quality measures as appropriate. We also have a dedicated email account, *HospiceAssessment@cms.hhs.gov,* for comments about HOPE. We will use field test results to create a final version of HOPE to propose in future rulemaking for national implementation. We will continue to inform all stakeholders throughout this process by using a variety of sub-regulatory channels and regular HQRP communication strategies, such as Open-Door Forums (ODF), Medicare Learning Network (MLN), *CMS.gov* website announcements, listserv messaging, and other ad hoc publicly announced opportunities. We appreciate the support for HOPE and reiterate our commitment to providing updates and engaging stakeholders through sub-regulatory means. HOPE updates can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE* and engagement opportunities, including those regarding HOPE are at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.*

We plan to provide additional information regarding HOPE testing results on the HQRP website in fall of 2023.

Comment: Public comments generally supported development of HOPE. However, commenters requested more stakeholder engagement and a generous implementation lead time. Several comments expressed concern about the potential administrative burden or workflow changes the new instrument would impose. Some commenters expressed interest in the role HOPE will play in advancing health equity, including voicing support for the collection of social risk data, including social determinants of health (SDOH) data. One commenter recommended that CMS review LCD guidelines in the context of health equity. One commenter encouraged CMS to recognize the role of occupational therapists within the IDG while finalizing HOPE.

Response: We appreciate all stakeholders' input regarding HOPE development and will take these comments into consideration. We are committed to developing and implementing HOPE with a minimum burden to stakeholders. Additional information about HOPE will be presented to the public as appropriate.

3. Update on Future Quality Measure (QM) Development

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we provided updates related to CMS's process for identifying high priority areas of quality measurement and improvement and for developing quality measures that address those priorities. Information on the current HQRP quality measures can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.*

In this final rule, we provide updates on the status of current HQRP measures, and the development of hospice quality measure concepts based on the future use of HOPE, administrative, and health equity data. On July 26, 2022, the CBE endorsed the claims-based Hospice Visits in the Last Days of Life measure (HVLDL). More information can be found on the HQRP Quality Measure Development web page: *https://www.cms.gov/medicare/hospice-quality-reporting-program/quality-measure-development.* 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: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact. Additional information about CMS's HOPE-based measure development efforts is available in the 2021 technical expert panel (TEP) Summary Reports and the 2021 Information Gathering Report, available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.*

Comment: Commenters were generally supportive of the two HOPE-based measures currently in development, but also requested additional information about the measure specifications and more stakeholder engagement opportunities. One commenter expressed concern about added regulatory burdens or workflow changes from adopting new quality measures. Several commenters encouraged CMS to allow reassessments to be completed telephonically or via remote patient monitoring (RPM), or to allow any member of the interdisciplinary care team to perform the assessment. Some commenters suggested reducing the reassessment

timeframe to one day instead of two, especially if the reassessment were allowed to be conducted telephonically. Commenters encouraged CMS to develop outcome measures as well as process measures, and to incorporate patient preferences into future quality measures.

Response: We appreciate all stakeholders' input regarding quality measure development and will take these comments into consideration for future QM development initiatives. We remain committed to building a robust, evidence-based set of HQRP measures that holistically and reliably reflect the quality of hospice care.

As development of the HOPE-based quality measures Timely Reassessment of Pain Impact and Timely Reassessment of Non-Pain Symptom Impact continues, CMS will keep stakeholders informed of progress and will offer opportunities for stakeholders to learn more and provide feedback. We appreciate the input regarding quality measure development and will take these comments into consideration for future QM development initiatives. We are committed to the Meaningful Measures Initiative (*https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy*) and Measures Management System Blueprint (*https://mmshub.cms.gov/blueprint-measure-lifecycle-overview*) that informs and guides quality measure development priorities and processes.

4. Health Equity Updates Related to HQRP

a. Background

In the FY 2023 Hospice Payment Rate Update proposed rule (87 FR 19442), we included a Request for Information (RFI) on hospices' current health equity activities and a future approach to advancing health equity in hospice. We define health equity as ''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.'' We are working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. CMS' goals outlined in the *CMS Framework for Health Equity 2022–2023* are in line with Executive Order 13985, ''Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.'' [5] The goals included in the *CMS Framework for Health Equity* serve to further advance health equity, expand coverage, and improve health outcomes for the more than 170 million individuals supported by our programs, and sets a foundation and priorities for our work, including: strengthening our infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working to eliminate barriers to CMS-supported benefits, services, and coverage.

In addition to the *CMS Framework for Health Equity,* CMS seeks to ''advance health equity'' as one of eight goals comprising the CMS National Quality Strategy (NQS).[6] The NQS identifies a wide range of potential quality levers that can support our advancement of equity, including: establishing a standardized approach for patient-reported data and stratification; employing quality and value-based programs to publicly report and incentivize closing equity gaps; and developing equity-focused performance metrics, regulations, oversight strategies, and quality improvement initiatives.

A goal of this NQS is to address persistent disparities that underly our healthcare system. Racial disparities, in particular, are estimated to cost the U.S. $93 billion in excess medical costs and $42B in lost productivity per year, in addition to economic losses due to premature deaths.[7] At the same time, racial and ethnic diversity has increased in recent years with an increase in the percentage of people who identify as two or more races accounting for most of the change, rising from 2.9 percent to 10.2 percent between 2010 and 2020.[8] Therefore, we need to consider ways to reduce disparities, achieve equity, and support our diverse population through the way we measure quality and display of data.

We solicited public comments via the aforementioned RFI on a potential health equity structural composite measure in the Hospice Quality Reporting Program. We refer readers to the FY 2023 Hospice Payment Rate Update final rule (87 FR 45669) for a summary of the public comments and suggestions received in response to the health equity RFI.

We took these comments into account, and we continue to work to develop policies, quality measures, and measurement strategies on this important topic. After considering public comments, CMS decided to convene a health equity technical expert panel to provide additional input to inform the development of health equity quality measures. The work of this technical expert panel is described in detail below.

Home Health and Hospice Health Equity Technical Expert Panel

To support new health equity measure development, the Home Health and Hospice Health Equity Technical Expert Panel (Home Health & Hospice HE TEP) was convened by a CMS contractor in Fall 2022. The Home Health & Hospice HE TEP comprised 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 providing input on a potential cross-setting health equity structural composite measure concept as set forth in the FY 2023 Hospice Payment Rate Update proposed rule (87 FR 19442) as part of an RFI related to the HQRP Health Equity Initiative. Specifically, the TEP assessed the face validity and feasibility of the potential structural measure. The TEP also provided input on possible confidential feedback report options to be used for monitoring health equity. TEP members also had the opportunity to provide ideas for additional health equity measure concepts or approaches to addressing health equity in hospice and home health settings.

Broad themes that recurred throughout discussions were community access and alignment between the community population and the organization's patient population. A detailed summary of the Home Health & Hospice HE TEP meetings and final TEP recommendations is available on the Hospice QRP Health Equity web page: *https://www.cms.gov/medicare/hospice-*

[5] *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.*

[6] Centers for Medicare & Medicaid Services. What is the CMS Quality Strategy? Available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy.*

[7] Ani Turner, The Business Case for Racial Equity, A Strategy for Growth, W.K. Kellogg Foundation and Altarum, April 2018.

[8] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

quality-reporting-program/hospice-qrp-health-equity. CMS is taking the TEP feedback into consideration as we continue to develop health equity concepts and policies related to HQRP.

Universal Foundation

To further the goals of 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. The development and implementation of the Preliminary Adult and Pediatric Universal Foundation Measures will promote the best, safest, and most equitable care for individuals as we all come together on these critical quality areas. As CMS moves forward with the Universal Foundation, we will be working to identify foundational measures in other specific settings and populations to support further measure alignment across CMS programs as applicable.

To learn more the impact and next steps of the Universal Foundation, read the recent publication of 'Aligning Quality Measures Across CMS—the Universal Foundation' in the New England Journal of Medicine.

b. Anticipated Future State

Possible Future Health Equity Efforts

We are committed to 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. Social determinants of health—social, economic, environmental, and community conditions—may have a stronger influence on the population's health and well-being than services delivered by practitioners and healthcare delivery organizations.[9] Given these impacts, measure stratification is important. Measure stratification helps identify disparities by calculating quality measure outcomes separately for different beneficiary populations. By looking at measure results for different populations separately, CMS and providers can see how care outcomes may differ between certain patient populations in a way that would not be apparent from an overall score (that is, a score averaged over all beneficiaries). This helps CMS to better fulfill our health equity goals. For example, when certain quality measures from the past two decades related to healthcare outcomes for children are stratified by race, ethnicity, and income, they show that important health disparities have been narrowed, because outcomes for children in the lowest income households and for Black and Hispanic children improved faster than outcomes for children in the highest income households or for White children.[10] This differential impact would not be apparent without stratification. This work supports our desire to understand with providers what can be learned from stratifying our quality measures by race, ethnicity, and income.

As part of our efforts to advance health equity in hospice, we are taking into consideration the health equity measures used in other health care provider settings. There are social determinants of health (SDOH) data items in the standardized patient assessment instruments used in the post-acute care (PAC) settings, and data items related to social drivers of health in acute care settings such as the hospital inpatient quality reporting program. We see value in aligning SDOH data items across all care settings and might consider adding SDOH data items used by other care settings into HQRP as we develop future health equity quality measures under our HQRP statutory authority.[11] This would further the NQS to align quality measures across our programs as part of the Universal Foundation.[12]

As we move this important work forward, we will continue to take input from hospice stakeholders into account and monitor the application of proposed health equity policies across CMS and other HHS initiatives. The Initial Proposals for Updating OMB's Race and Ethnicity Statistical Standards, 88 FR 5375, sought public comments through April 27, 2023. Also, the Office of the National Coordinator for Health IT (ONC) welcomes input on data classes and data elements for future versions of the United States Core Data for Interoperability (USCDI)—a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange.[13] In addition, while the anticipated health equity efforts that impact policy changes would proceed through the notice and comment rulemaking process, other activities would be completed through sub-regulatory channels and regular communication strategies, such as Open-Door Forums, Medicare Learning Network, *CMS.gov* website announcements, listserv messaging, and other opportunities.

Comment: Commenters generally encouraged CMS to expand health equity measurement. However, several commenters encouraged CMS to wait until HOPE is implemented to better utilize that instrument for health equity measurement. These commenters expressed concern about implementing new health equity measures without an established instrument that could be used to track relevant patient data. Another commenter suggested that CMS review LCD guidelines for health equity guidance.

Response: We appreciate all stakeholder feedback received regarding health equity. These comments will help inform our future efforts to incorporate health equity and social determinants of health into HQRP. We will consider the implications of HOPE implementation for ongoing health equity efforts.

5. CAHPS Hospice Survey Updates

CAHPS Hospice Survey Mode Experiment

In the FY 2023 Hospice Payment Rate Update final rule (87 FR 45669), we provided information on a mode experiment CMS conducted in 2021. The purpose of the experiment was to test:

- A web-mail mode (email invitation to a web survey, with mail follow-up to non-responders).
- A revised survey version, which is shorter and simpler than the current survey, and includes new questions on topics suggested by stakeholders.
- Modifications to survey administration protocols designed to improve overall response rates, such as a prenotification letter and extended field period.

Fifty-six large hospices participated in the mode experiment, representing a range of geographic regions, ownership,

[9] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

[10] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

[11] *https://www.nejm.org/doi/full/10.1056/NEJMp2215539,* February 1, 2023.

[12] *https://www.nejm.org/doi/full/10.1056/NEJMp2215539,* February 1, 2023.

[13] *https://www.healthit.gov/sites/isa/files/2023-01/Draft-USCDI-Version-4-January-2023-Final.pdf.*

and past performance on the CAHPS Hospice Survey. A total of 15,515 decedents/caregivers were randomly sampled from these hospices. Sampled decedents/caregivers were randomly assigned to one of four modes of administration (mail only, telephone only, mail-telephone, webmail); mail only cases were randomly assigned to be administered either the revised or the current survey.

The information received on the CAHPS Hospice Survey Mode Experiment CMS conducted in 2021, resulted in the following findings:

- Response rates to the revised survey were 35.1 percent in mail only mode, 31.5 percent in telephone only mode, 45.3 percent in mail-telephone, and 39.7 percent in webmail mode.
- Response rates to web-mail mode were similar to mail only mode for those without email addresses (35.2 percent vs. 34.4 percent), but 13 percentage points higher for those with email addresses (49.6 percent vs. 36.7 percent).
- Response rates to mail-only administration of the revised and current survey were similar (35.1 percent vs. 34.2 percent).
- Mailing of a prenotification letter resulted in an increased response rate of 2.4 percentage points.
- Extending the field period to 49 days (from the current 42 days) resulted in an increased response rate of 2.5 percentage points in the mail only mode.

In addition, the following changes were tested as part of the revised CAHPS Hospice Survey:

- Removal of one survey item regarding confusing or contradictory information from the Hospice Team Communication measure.
- Replacement of the multi-item Getting Hospice Care Training measure with a new, one-item summary measure.
- Addition of a new, two-item Care Preferences measure.
- Simplified wording to component items in the Hospice Team Communication, Getting Timely Care, and Treating Family Member with Respect measures.

CMS 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. We are not finalizing any changes in this rule.

Comment: Commenters overwhelmingly supported implementation of a web based CAHPS® Hospice Survey mode. Several commenters also encouraged CMS to review the CAHPS® Hospice Survey through an equity lens, including looking for opportunities to increase response rates for non-English-speaking families, making the survey available in more languages, and ensuring that survey questions are culturally sensitive. Several commenters recommended that CMS shorten or simplify the survey to make it easier for caregivers to complete. One commenter asked CMS to provide more clarification to caregivers of patients who resided in facilities or had recent hospitalizations, as caregivers may become confused about which survey applies to each care setting. Once commenter encouraged CMS to collect CAHPS® Hospice Survey responses from families and caregivers closer to the time of a patient's death. Another commenter observed that the CAHPS® Hospice Survey is unique, as the individual who completes the survey is not the patient who received the service and may have different perceptions of the care provided. One commenter also encouraged CMS to update Care Compare without explicit suggested updates.

Response: We thank commenters for their interest in the CAHPS® Hospice Survey. We appreciate the support of a web-based mode of survey administration and simpler CAHPS® Hospice Survey instrument. If and when a web-based mode is made available as one of the approved modes of CAHPS Hospice Survey administration, hospices would continue to have the option to choose among all approved modes (that is, web-based mode would not be required). Prior to introducing a revised survey instrument and/or new approved mode of administration, we will release detailed information regarding proposed changes to survey instrument content, survey administration protocols, and data adjustment procedures needed to promote fair comparisons between hospices selecting different modes of survey administration.

The CAHPS® Hospice Survey will continue to be completed by caregivers. The Hospice CAHPS Survey is completed by the primary caregiver out of respect for the patient receiving end of life care. We believe it would not be appropriate to have hospice patients fill out a survey about the care they are receiving at the very end of their life. We will also consider opportunities to make the CAHPS® Hospice Survey easier for caregivers to understand and complete.

We will consider commenters' feedback and suggestions in the context of ongoing efforts to improve health equity. We also encourage hospices to consider their patient/caregiver population and work with their survey vendor to determine the best mode of data collection.

6. Form, Manner, and Timing of Quality Data Submission

a. Statutory Penalty for Failure to Report

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act was amended by the CAA, 2021 and the payment reduction for failing to meet hospice quality reporting requirements is increased from 2 percent to 4 percent beginning with FY 2024. The Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points and then beginning in FY 2024 and for each subsequent year, the Secretary shall reduce the market basket percentage increase by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. In the FY 2023 Hospice Wage Index and Payment Rate Update proposed rule (87 FR 19442), we revised our regulations at § 418.306(b)(2) in accordance with this statutory change (86 FR 42605). We are not proposing any new public reporting proposals in this rule.

b. Compliance

HQRP Compliance requires understanding three timeframes for both HIS and CAHPS: (1) The relevant Reporting Year, payment FY and the Reference Year. The ''Reporting Year'' (HIS)/''Data Collection Year'' (CAHPS). This timeframe is based on the calendar year (CY). It is the same CY for both HIS and CAHPS. If the CAHPS Data Collection year is CY 2023, then the HIS reporting year is also CY 2023; (2) The APU is subsequently applied to FY payments based on compliance in the corresponding Reporting Year/Data Collection Year; and (3) For the CAHPS Hospice Survey, the Reference Year is the CY before the Data Collection Year. The Reference Year applies to hospices submitting a size exemption from the CAHPS survey (there is no similar exemption for HIS). For example, for the CY 2023 data collection year, the Reference Year, is CY 2022. This means providers seeking a size exemption for CAHPS in CY 2023 will base it on their

hospice size in CY 2022. Submission requirements are codified in § 418.312.

For every CY, all Medicare-certified hospices are required to submit HIS and CAHPS data according to the requirements in § 418.312. Table 6 summarizes the three timeframes. It illustrates how the CY interacts with the FY payments, covering the CY 2022 through CY 2025 data collection periods and the corresponding APU application from FY 2024 through FY 2027.

TABLE 6: HQRP Reporting Requirements and Corresponding Annual Payment Updates

Reporting Year for HIS and Data Collection Year for CAHPS data	Annual Payment Update 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

As illustrated in Table 7, CY 2022 data submissions compliance impacts the FY 2024 APU. CY 2023 data submissions compliance impacts the FY 2025 APU. CY 2024 data submissions compliance impacts FY 2026 APU. This CY data submission impacting FY APU pattern follows for subsequent years.

c. Submission of Data Requirements

As finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142, 47192), hospices' compliance with HIS requirements beginning with the FY 2020 APU determination (that is, based on HIS Admission and Discharge records submitted in CY 2018) are based on a timeliness threshold of 90 percent. This means CMS requires that hospices submit 90 percent of all required HIS records within 30 days of the event (that is, patient's admission or discharge), known. The 90-percent threshold is hereafter referred to as the timeliness compliance threshold. Ninety percent of all required HIS records must be submitted and accepted within the 30-day submission deadline to avoid the statutorily-mandated payment penalty. Hospice compliance with claims data requirements is based on administrative data collection. Since Medicare claims data are already collected from claims, hospices are considered 100 percent compliant with the submission of these data for the HQRP. There is no additional submission requirement for administrative data.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey. Hospices comply by utilizing a CMS-approved third-party vendor. Approved Hospice CAHPS vendors must successfully submit data on the hospice's behalf to the CAHPS Hospice Survey Data Center. A list of the approved vendors can be found on the CAHPS Hospice Survey website: *www.hospicecahpssurvey.org.* Table 7. HQRP Compliance Checklist illustrates the APU and timeliness threshold requirements.

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 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

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

Most hospices that fail to meet HQRP requirements do so because they miss the 90 percent threshold. We offer many training and education opportunities through our website, which are available 24/7, 365 days per year, to enable hospice staff to learn at the pace and time of their choice. We want hospices to be successful with meeting the HQRP requirements. We encourage hospices to use the website at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training-Training-and-Education-Library*. For more information about HQRP Requirements, we refer readers to visit the frequently-updated HQRP website and especially the Best Practice, Education and Training Library, and Help Desk web pages at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting*. We also encourage readers to visit the HQRP web page and sign-up for the Hospice Quality ListServ to stay informed about HQRP.

d. Codification of HQRP Data Completion Thresholds

As previously noted, we proposed to add a new paragraph (j) to § 418.312 for data completion thresholds. In the FY 2016 Hospice Wage Index final rule (80 FR 47192 through 47193), we finalized HQRP thresholds for completeness of HQRP data submissions. To ensure that hospices are meeting an acceptable standard for completeness of submitted data, we finalized the policy that, beginning with the FY 2018 HQRP, hospices must meet or exceed one data submission threshold. Hospices must meet or exceed a data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (that is, patient's admission or discharge).

Under our finalized policy, some assessment data did not obtain a response and, in those circumstances, are not ''missing'' nor is the data incomplete. For example, in the case of a patient who does not have any of the medical conditions in a ''check all that apply'' listing, the absence of a response of a health condition indicates that the condition is not present, and it would be incorrect to consider the absence of such data as missing in a threshold determination.

In the FY 2017 Hospice Wage Index proposed rule, we received comments on our previously finalized policies for form, manner, and timing of data collection. These public comments were considered and summarized in the FY 2017 Hospice Wage Index final rule. In the FY 2022 Hospice Wage Index and Payment Rate Update final rule and the FY 2023 Hospice Wage Index and Payment Rate Update final rule, we provided an HQRP Compliance Checklist, which illustrated additional details about how the compliance thresholds applied to APUs by FY.

We proposed to, and are finalizing the decision to, codify these data completeness thresholds at § 418.312(j)(1) for measures data collected using the HIS or a successor

instrument. Under this section, we proposed to codify our requirement that hospices must meet or exceed a data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (that is, patient's admission or discharge) and submit the data through the CMS designated data submission systems. This threshold would apply to all HIS or successor instrument-based measures and data elements adopted into HQRP. We are also finalizing the decision to codify § 418.312(j)(2) that a hospice must meet or exceed this threshold to avoid receiving a 4-percentage point reduction to its annual payment update for a given FY as codified at § 418.306(b)(2).

We solicited public comment on our proposal to codify in regulations text the HQRP data completion thresholds at § 418.312(j) for measures and standardized patient assessment elements collected using the HIS or successor instrument and compliance threshold to avoid receiving 4 percentage point reduction as described under § 418.306(b)(2).

Comment: One commenter supported CMS's proposal to codify the data submission requirements, but encouraged CMS to amend the requirements in future rulemaking once HOPE is officially proposed for data collection. One commenter expressed concern that the proposed data submission threshold would be overly burdensome for hospices that are already struggling with technological or other barriers to meeting HQRP requirements.

Response: We appreciate stakeholders' feedback and engagement related to HQRP. We are finalizing the data submission thresholds regulation text at § 418.312(j) as established in prior rulemaking. We may consider revisions to data collection thresholds when implementing HOPE in future rulemaking. The 4 percent APU penalty is established at § 418.306(b)(2).

D. Establishing Hospice Program Survey and Enforcement Procedures Under the Medicare Program; Provisions Update (CAA, 2021, Section 407)

Division CC, section 407 of the CAA, 2021, amended Part A of Title XVIII of the Act to add a new section 1822, and amended sections 1864(a) and 1865(b) of the Act, establishing new hospice program survey and enforcement requirements, required public reporting of survey information, and a new hospice hotline.

This law (CAA, 2021) requires public reporting of hospice program surveys conducted by both State Agencies (SAs) and Accrediting Organizations (AOs), as well as enforcement actions taken as a result of these surveys on the CMS website in a manner that is prominent, easily accessible, searchable, and presented in a readily understandable format. It removes the prohibition at section 1865(b) of the Act of public disclosure of hospice surveys performed by AOs, and requires that AOs use the same survey deficiency reports as SAs (Form CMS–2567, ''Statement of Deficiencies'' or a successor form) to report survey findings.

The CAA, 2021 also requires hospice programs to measure and reduce inconsistency in the application of survey results among all hospice program surveyors, and requires the Secretary to provide comprehensive training and testing of SA and AO hospice program surveyors, including training with respect to review of written plans of care. The CAA, 2021 prohibits SA surveyors from surveying hospice programs for which they have worked in the last 2 years or have a financial interest, requires hospice program SAs and AOs to use a multidisciplinary team of individuals for surveys conducted with more than one surveyor to include at least one RN and provides that each SA must establish a dedicated toll-free hotline to collect, maintain, and update information on hospice programs and to receive complaints.

The provisions in the CAA, 2021 also direct the Secretary to create a Special Focus Program (SFP) for poor-performing hospice programs, sets out authority for imposing enforcement remedies for noncompliant hospice programs, and requires the development and implementation of a range of remedies as well as procedures for appealing determinations regarding these remedies. These remedies can be imposed instead of, or in addition to, termination of a hospice programs' participation in the Medicare program. The remedies include civil money penalties (CMPs), suspension of all or part of payments, and appointment of temporary management to oversee operations.

In the CY 2022 Home Health Prospective Payment System (HH PPS) final rule (86 FR 62240), we addressed provisions related to the hospice survey enforcement and other activities described in this section. A summary of the finalized CAA, 2021 provisions can be found in the CY 2022 HH PPS final rule: *https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.* We finalized all the CAA provisions in CY 2022 rulemaking except for special focus program (SFP). As outlined in the CY 2022 HH PPS final rule, we stated that we would take into account comments that we received and work on a revised proposal, seeking additional collaboration with stakeholders to further develop the methodology for the SFP since the publication of the CY 2022 HH PPS final rule.

In the FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (87 FR 45669) final rule, we affirmed our intention to initiate a hospice special focus program Technical Expert Panel (TEP) to provide input on the structure and methodology of the SFP. Public comments received in response to the FY 2023 Hospice Wage Index and Payment Rate Update proposed rule were generally supportive of CMS's efforts to establish an SFP and to convene a TEP to provide feedback on the development of the SFP. A TEP convened by a CMS contractor provided feedback and considerations on the preliminary SFP concepts, including the development of a methodology to identify hospice poor-performers, as well as graduation and termination criteria, and public reporting. A 30-day call for nominations was held July 14 through August 14, 2022 and nine TEP members were selected, representing a diverse range of experience and expertise related to hospice care and quality. Details from the TEP meetings, including their recommendations, are available in the TEP summary report [14] on the CMS website at *https://www.cms.gov/medicare/quality-safety-oversight-certification-compliance/hospice-special-focus-program.* The final TEP feedback is publicly available on the CMS website.

Accordingly, we proposed to implement an SFP in the CY 2024 Home Health Prospective Payment Update Rate proposed rule, which will be available on the Home Health Prospective Payment System Regulations and Notices page of the CMS website: *https://www.federalregister.gov/public-inspection/2023-14044/medicare-program-calendar-year-2024-home-health-prospective-payment-system-rate-update-home-health.*

Comment: Several public comments expressed concerns about the SFP and asked for further information as CMS designs this program. Commenters emphasized the need for a standardized survey process and increased training to better educate surveyors on hospice regulations. Some commenters

[14] 2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report (April 28, 2023).

expressed concern about a quota system being used for the SFP. Commenters encouraged CMS to focus on problematic and non-compliant hospices and asked that non-compliant hospices receive an opportunity to rectify their issues prior to being penalized. One comment simply noted and appreciated the SFP update.

Response: We appreciate stakeholders' interest and engagement related to the hospice SFP. We will consider these comments as we continue to develop the SFP.

E. Hospice Certifying Physician Enrollment

1. Medicare Provider Enrollment

Section 1866(j)(1)(A) of the Act requires the Secretary to establish a process for the enrollment of providers and suppliers into the Medicare program. The overarching purpose of the enrollment process is to help confirm that providers and suppliers furnishing services or items (or ordering/certifying the provision thereof) to Medicare beneficiaries meet all applicable federal and state requirements. The process is, to an extent, a ''gatekeeper'' that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. Since 2006, we have undertaken rulemaking efforts to outline our enrollment procedures. These regulations are generally codified in 42 CFR part 424, subpart P (currently §§ 424.500 through 424.575 and hereafter occasionally referenced as subpart P). They address, among other things, requirements that providers and suppliers must meet to enroll in Medicare.

As outlined in § 424.510, one requirement is that 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 (OMB Control No. 0938–0685). The Form CMS–855, which can be submitted via paper or electronically through the internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process (SORN: 09–70–0532), 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. We believe this screening process has greatly assisted CMS in executing its responsibility to prevent Medicare fraud, waste, and abuse.

As previously mentioned, over the years we have issued various final rules pertaining to provider enrollment. These rules were intended not only to clarify or strengthen certain components of the enrollment process but also to enable us to take further action against providers and suppliers: (1) engaging (or potentially engaging) in fraudulent or abusive behavior; (2) presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Funds; or (3) that are otherwise unqualified to furnish Medicare services or items. Consistent with this, and for reasons explained in section III.E.2. of this rule, we proposed to require physicians who certify hospice services for Medicare beneficiaries (hereafter occasionally referenced as ''hospice physicians'') to be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question.

2. Statutory and Policy Background

Section 6405(a) of the Affordable Care Act (which amended section 1834(a)(11)(B) of the Act) states that the Secretary may require that a physician ordering durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) be enrolled in Medicare for payment for the DMEPOS item to be made. Section 6405(b) of the Affordable Care Act (which amended sections 1814(a)(2) and 1835(a)(2) of the Act) contains a similar provision regarding the certification of a physician (or certain eligible professionals) for Part A and B home health services. Section 6405(c) of the Affordable Care Act, meanwhile, authorizes the Secretary to extend the requirements of sections 6405(a) and (b) to all other categories of items or services under title XVIII of the Act (including covered Part D drugs) that are ordered, prescribed, or referred by a physician or eligible professional enrolled in Medicare under section 1866(j) of the Act.

Pursuant to this authority, we finalized 42 CFR 424.507(a) and (b) in an April 27, 2012 final rule titled ''Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements'' (77 FR 25284). Sections 424.507(a) and (b) collectively state that for payment to be made for ordered imaging services, clinical laboratory services, DMEPOS items, or home health services, the service or item must have been ordered or certified by a physician or, when permitted, an eligible professional who—(1) is enrolled in Medicare in an approved status; or (2) has a valid opt-out affidavit on file with a Part A and B MAC. The purpose of § 424.507(a) and (b) is to confirm that the physicians and eligible professionals who order or certify the items and services referenced in those paragraphs are qualified.

We constantly review program integrity trends to determine whether certain provider and supplier types and services warrant closer scrutiny from a provider enrollment perspective. During this process, we have remained ready to propose expansions to § 424.507(a) and (b) should circumstances warrant. We believe that the latter situation currently exists with respect to hospices.

The OIG in July 2018 issued a study titled ''Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity'' (OEI–02–16–00570). This report noted that Medicare in 2016 spent about $16.7 billion for hospice care for 1.4 million beneficiaries, up from $9.2 billion for fewer than 1 million beneficiaries in 2006.'' [15] The report described how some hospice fraud schemes involved paying recruiters to target beneficiaries who are not eligible for hospice care; other schemes involved physicians falsely certifying beneficiaries as terminally ill when they were not.[16] (Pursuant to 42 CFR 418.20(b), a physician must certify the beneficiary as being terminally ill for the beneficiary to be eligible to elect hospice care.) The OIG cited several examples of this behavior, including the following:

- Two certifying physicians from a California hospice were convicted of health care fraud for falsely certifying beneficiaries as terminally ill. The false certifications were part of a wider fraud scheme that the hospice owner organized. The scheme involved illegal payments to patient recruiters for bringing in beneficiaries, establishing fraudulent diagnoses, and altering medical records.[17]
- A Mississippi hospice owner used patient recruiters to solicit beneficiaries who were not eligible for hospice care. These patients were unaware of their enrollment in hospice care. The owner submitted fraudulent charges and received more than $1 million from Medicare.[18]

[15] *https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf,* p. 1.

[16] Ibid., 6.

[17] Ibid., p. 7.

[18] Ibid.

• A Minnesota-based hospice chain agreed to pay $18 million to resolve allegations that it improperly billed Medicare for care provided to beneficiaries who were ineligible for hospice because they were not terminally ill. The hospice chain also allegedly discouraged physicians from discharging ineligible beneficiaries.[19]

• A hospice physician improperly certified a beneficiary who a hospital determined to be in ''good shape'' only days before as terminally ill.[20]

• A hospice falsely informed a beneficiary that she could remain on a liver transplant list even if she chose hospice care. However, she was removed from the transplant list when she elected hospice care. When the beneficiary learned of this, she ceased hospice care so she could be reinstated on the transplant list.[21]

• A physician received kickbacks for recruiting beneficiaries, many of whom were not terminally ill but seeking opioids.[22]

More generally, the OIG expressed concern that: (1) beneficiaries are put at risk when they are inappropriately enrolled in hospice care because they might be unwittingly forgoing needed treatment; [23] (2) ''some hospice physicians are not always meeting requirements when certifying beneficiaries for hospice care;'' [24] and (3) hospice fraud schemes are growing.[25]

The Government Accountability Office (GAO) in October 2019 issued a report titled, ''Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers'' (GAO–20–10).[26] The GAO observed therein that the number of: (1) Medicare hospice beneficiaries had almost tripled to nearly 1.5 million by FY 2017; and (2) Medicare hospice providers had doubled.[27] The GAO stated that in light of this growth: ''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.'' [28]

In light of the foregoing, we believe that expanding § 424.507(a) and (b) to include hospice services could strengthen the program integrity aspect of physician certifications. The careful screening that the enrollment process entails would help us 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 (as that term is defined in § 424.502). If an unenrolled physician certifies a Medicare beneficiary's need for hospice care, we have insufficient background on the physician to know whether he or she was qualified to do so or has an adverse history. We believe that some of the aforementioned examples of improper behavior the OIG found can be at least partially avoided through closer vetting of the physician. Moreover, the screening process could help foster beneficiary health and safety by ensuring the physician is appropriately licensed.

3. Proposed Provisions

Using our authority under section 6405(c) of the Affordable Care Act, we accordingly proposed the following revisions to § 424.507.

First, the current title of § 424.507(b) states, ''Conditions for payment of claims for covered home health services''. We proposed to add ''and hospice'' between ''health'' and ''services'' to account for our intended inclusion of hospice services within § 424.507(b).

Second, the introductory paragraph of § 424.507(b) reads: ''To receive payment for covered Part A or Part B home health services, a provider's home health services claim must meet all of the following requirements:'' To accommodate hospice services, we proposed to revise this to state: ''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:''

Third, the opening language of § 424.507(b)(1) states: ''The ordering/certifying physician, or the ordering/certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law . . .''. Under 42 CFR 418.22(b), and as alluded to previously, only a physician (which can include the hospice's medical director) can certify that the beneficiary is terminally ill. We proposed to revise the beginning of § 424.507(b)(1) to state: ''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 . . .''. This would help clarify that § 424.507(b)(1) should not be read to imply that the eligible professionals listed therein can certify the beneficiary's terminal status.

Fourth, §§ 418.22(c)(1)(i) and (ii) state that for the initial 90-day hospice period, the following physicians, respectively, must certify that the beneficiary is terminally ill: (1) the hospice's medical director or the physician member of the hospice interdisciplinary group (hereafter occasionally referenced collectively as the ''hospice physician''); and (2) the individual's attending physician (who must meet the definition of physician in § 410.20) if the beneficiary has one. For subsequent hospice periods, § 418.22(c)(2) states that only one of the physicians in § 418.22(c)(1)(i) must provide the certification. Given the hospice program integrity concerns previously mentioned, we believed that each certification required under § 418.22(c) should be by an enrolled or validly opted-out physician. Therefore, we proposed to add § 424.507(b)(3) to reflect this requirement and would refer therein to the requirements of § 418.22(c).

4. Comments Received and Responses

We received approximately 21 pieces of timely correspondence in response to our proposal. These comments are summarized below. Our responses are also included.

Comment: Several commenters supported our proposal. One commenter stated that it could help identify physicians who engage in fraudulent or abusive behavior that puts Medicare beneficiaries at risk.

Response: We appreciate the commenters' support.

Comment: Several commenters expressed concern about the impact of requiring the hospice physician to be enrolled. Their concerns fell into three principal categories. First, they believed that having to ascertain the physician's enrollment/opt-out status would be administratively burdensome on hospices, with one commenter stating that home health agencies (HHAs) have been similarly burdened when verifying the enrollment/opt-out status of the home health certifying physician. Second, if the hospice physician is neither enrolled nor opted-out, the hospice will need to find another hospice physician (such as the physician member of the hospice interdisciplinary group) to sign the certification, which could postpone patient care. Third, various hospices employ or contract with physicians who are neither enrolled nor opted-out by choice. The commenters believed some of these physicians would resign or end

[19] Ibid.
[20] Ibid., p. 6.
[21] Ibid.
[22] Ibid., p. 12.
[23] Ibid., p. 6.
[24] Ibid., p. 12.
[25] Ibid.
[26] *https://www.gao.gov/assets/gao-20-10.pdf.*
[27] Ibid., p. 25.
[28] Ibid.

their contract with the hospice rather than enroll or opt-out, hence requiring the hospice to hire replacement physicians. This could prove difficult, however, because requiring the hospice physician to be enrolled or opted-out might limit the pool of prospective physicians, since some physicians will not wish to seek employment or a contractual relationship with the hospice if they have to enroll or opt-out. Especially in rural areas, this could result in further shortages of hospice physicians, which, in turn, might harm patient care.

Response: We appreciate these comments and address them as follows.

We do not foresee a significant administrative burden associated with confirming the hospice physician's and attending physician's enrollment/opt-out statuses. Hospices can quickly verify said status using the CMS ordering and referring data file (ORDF),[29] which lists all Medicare-enrolled and opted-out physicians. HHAs, DMEPOS suppliers, and suppliers of clinical laboratory and imaging services currently use this same means of verifying an ordering/certifying/referring physician's enrollment/opt-out status, and we have not been notified by these providers and suppliers of any substantial burden associated with this activity.

Concerning the commenters' second and third assertions, we believe the situations they cite regarding unenrolled or non-opted out hospice physicians will be exceedingly rare. We estimated in the ICR section of the proposed rule that 2,173 certifying physicians would need to enroll or opt-out in order to certify hospice services. This is a very small number given the universe of over 2 million physicians nationwide, and most certifying physicians are already enrolled or opted-out. We are also confident that the vast preponderance of those who currently are not will choose to enroll or opt-out, and one commenter, in fact, agreed with this based on feedback received from the hospice community. Indeed, this was our experience when we implemented the aforementioned DMEPOS, HHA, and imaging and clinical laboratory services requirement; in general, those physicians and practitioners who were neither enrolled nor opted-out elected to complete the enrollment/opt-out process in order to continue ordering/certifying/referring the services and items in question. We believe the same will occur with our hospice proposal, and we do not expect the physician shortages or postponements in care that the commenters mentioned to occur.

Comment: A number of commenters opposed our proposed requirement in new § 424.507(b)(3) to also require the beneficiary's attending physician to be enrolled/opted-out. Their concerns were generally as follows.

First, requiring the attending physician's enrollment/opt-out infringes upon the patient's right to choose their designated attending physician.

Second, if the attending physician is neither enrolled nor opted-out, the beneficiary would have to find a new attending physician if they wish to have one. This could delay the patient's hospice admission and their consequent ability to receive pain management and palliative care. The patient may even be too ill to select a new attending physician or may pass before making their selection. All of this would place a tremendous and unnecessary burden on the beneficiary and their family or representative. Commenters stated that these vulnerable patients in such cases should not have to effectively end their relationship with the attending physician (who, in many cases, may have been the patient's primary care physician for years) in order to receive hospice services.

Third, and in the previous scenario, the hospice, too, would be burdened. The hospice would have to communicate the attending physician's non-enrollment/opt-out status to the beneficiary and, in some cases, assist in finding a new one. Moreover, the hospice may have received a directive from the designated attending physician to address immediate patient needs but would have to re-obtain the directive from a different physician, during which delay the patient may pass.

Fourth, commenters stated that simply requiring the hospice physician to be enrolled or opted-out should be a sufficient program integrity safeguard since both the hospice physician and the attending physician (if the beneficiary has one) must certify the initial hospice episode. The attending physician can thus further verify the validity of the hospice physician's certification.

In addition, a commenter contended that since the hospice physician oversees the beneficiary's plan of care per 42 CFR 418.56(a)(1)(i), this physician's enrollment or opt-out status alone should serve as an adequate payment safeguard without the need to require the attending physician to be enrolled or opted-out.

Response: We appreciate these comments and understand the concerns expressed. We address them in turn.

First, we do not believe our requirement would infringe upon any beneficiary right to choose their attending physician. The beneficiary would not only retain the ability to select a new attending physician if their chosen one is unenrolled/non-opted out but also need not choose to have one at all. Furthermore, this attending physician requirement only applies to the signing of the initial certification. It does not prohibit the beneficiary's desired attending physician from treating the beneficiary in the hospice and then billing for these services under Part B, though we note that in that case the physician must be enrolled. We therefore respectively disagree that our requirement restricts the patient's right to select their attending physician or compels the beneficiary to terminate any relationship therewith. Our proposal, to reiterate, is strictly limited to the attending physician's initial certification and does not affect the larger beneficiary-physician relationship.

Second, and as we previously explained with respect to hospice physicians, we believe the situation the commenters describe will be extremely rare. In the overwhelming preponderance of cases, a beneficiary's attending physician furnishes services to many patients other than the beneficiary; for instance, many attending physicians have a private practice that treats numerous patients for matters unrelated to hospice certifications. This means that the attending physician is very likely already enrolled/opted-out and hence can sign the hospice beneficiary's certification. We reemphasize that the number of unenrolled and non-opted out physicians who certify hospice services is very small and that, in our view, these physicians would choose to enroll or opt-out pursuant to our requirement.

Concerning the commenters' third assertion, we again do not anticipate the excessive burdens on the hospice community (including compliance with the 2-day period) that the commenters cite given the very small number of currently unenrolled and non-opted out certifying physicians.

Finally, we disagree with the commenters' contention that merely requiring the hospice physician's enrollment/opt-out status should be adequate to meet CMS' program integrity concerns. To the contrary, our definition of attending physician in § 418.3 describes the latter 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

[29] *https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring/data.*

determination and delivery of the individual's medical care. Given this relationship, we believe it is particularly important that the attending physician be properly screened before furnishing the required certifying statement.

Comment: A commenter asked CMS to clarify that the term ''ordering/certifying physician'' for purposes of our proposal does not include the referring/attending physician.

Response: We are finalizing our proposal that attending physicians must be enrolled or opted-out to certify hospice services. We note, however, that the term ''ordering'' is largely immaterial for purposes of the certifications required per § 418.22. That is, in the context of § 424.507, ''ordering and certifying'' collectively references all the services and items addressed in § 424.507 that a physician or practitioner may order or certify. Yet ''ordering'' mostly pertains to DMEPOS items and clinical laboratory and imaging services, whereas hospice and home health services involve certification of the need for said services. As such, the remainder of this section III.E will simply reference the ''certification'' of hospice services rather than the ''ordering or certifying'' thereof.

Comment: A commenter sought elucidation on two issues. The first was whether and how the hospice must document that the attending physician's enrollment or opt-out status was verified. The second was how the hospice should proceed if the patient's chosen attending physician is neither enrolled nor opted-out; the commenter asked whether the patient in that case is deemed ineligible for hospice care or the hospice should assign its own attending physician.

Response: Section 424.507(b) does not itself require the documentation of verification of the attending physician's enrollment/opt-out status. However, the hospice is ultimately responsible for confirming this status. Concerning the commenter's second issue, if the patient designates an attending physician that is neither enrolled nor opted-out, the certification of terminal illness for the initial 90-day benefit period would not be valid under § 418.22(c). If the beneficiary wants to designate a different attending physician, they may choose to do so. If they elect not to designate an attending physician, only the hospice certifying physician would certify the beneficiary's eligibility for the hospice benefit and he or she must be enrolled or opted-out. This is because the requirement that the hospice certifying physician and the designated attending physician both must sign the initial certification only applies if the beneficiary designates an attending physician. If the beneficiary does not have one, only the hospice certifying physician must sign the certification.

Comment: Several commenters recommended that CMS delay implementation of our proposal in order to allow physicians enough time to enroll or opt-out and for CMS to (1) make system changes and (2) perform outreach. They stated that hospices, too, will need time to educate their employed physicians, contracted physicians, and prospective patients. Suggestions included a 1-year delay.

Response: We agree that a delay in implementation is warranted for the reasons the commenters outlined. We believe that an additional seven-months is ample time to ensure certifying hospice and attending physicians meet all Medicare requirements, given the pressing program integrity concerns as previously discussed. Further, we believe a May 1, 2024 implementation date strikes a sound balance between addressing our payment safeguard concerns while giving stakeholders time to prepare. Accordingly, 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).

Comment: Several commenters asked whether unenrolled and non-opted-out physicians can serve as hospice medical directors.

Response: Our provision is restricted to the matter of payment of hospice Medicare claims and the certifications addressed in § 418.22 in the sole context of provider enrollment. Put otherwise, the hospice physician, whether the medical director or physician member of the interdisciplinary group, must be enrolled or opted-out to certify beneficiary eligibility and for payment to consequently be made.

Comment: Commenters expressed concern that if the patient must designate a new attending physician because the physician is neither enrolled nor opted-out, the hospice may be unable to obtain a new certification from a new attending physician within the required 2-day timeframe from the effective date of the hospice election period. (Per § 418.22(a)(3)(i), if the hospice cannot obtain the written certification required under § 418.22(a)(1) within 2 calendar days after an election period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.) Commenters stated that this would negatively impact the hospice from a financial perspective since payment could be denied due to a late certification. Additionally, a commenter outlined a scenario where a patient or representative designates an attending physician on the election statement who is neither enrolled nor opted-out; when the hospice realizes that this is the case the patient may have passed, or the hospice cannot contact the patient's representative to change the designated attending physician on the election statement. This commenter further asked whether the hospice must include the attending physician listed on the election statement on the hospice claim form in such situations.

Response: As we previously stated, there is a very small number of currently unenrolled and non-opted-out certifying physicians, so we do not believe this will be a common issue. Hospices should check the ORDF to determine the designated attending physician's enrolled/opt-out status. A good standard of practice would be for the hospice to check the ORDF in real time at the time the patient or representative is signing the election statement that includes the designation of an attending physician, or very shortly thereafter. As outlined in § 418.22, a certification of terminal illness can be completed up to 15 days prior to the start of the election period. Additionally, as outlined in § 418.24(b)(4), the election statement must include the effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. These flexibilities in our regulations should allow hospices to ensure that they are complying with the requirement for the certifying physician(s) to be enrolled or opted-out of Medicare. The designated attending physician listed on the hospice election statement must match the information contained in the ''Attending Provider Name and Identifiers'' field on the institutional claim if the attending physician is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or the ''Other Provider Name and Identifiers'' field on the institutional claim if the designated attending physician is a nurse practitioner or physician assistant. To change the designated attending physician, the patient or representative must sign a statement that outlines the change in accordance with the regulations at § 418.24(h).

Comment: A commenter asked how CMS would identify when the attending physician is a physician assistant or nurse practitioner and waive the claim from enrollment edits.

Response: An attending physician is defined in § 418.3 as one of the following:

- A Doctor of Medicine (M.D.) or osteopathy (D.O.) legally authorized to practice medicine and surgery by the state in which he or she performs that function or action;
- A nurse practitioner who meets the training, education, and experience requirements as described in § 410.75(b); or
- A physician assistant who meets the requirements of § 410.74(c).

However, section 1814(a)(7)(A)(i)(I) of the Act does not permit a nurse practitioner or a physician assistant to certify that the patient is terminally ill. As outlined in the Medicare Claims Processing Manual, Section 30.3 of Chapter 11, the ''Attending Provider Name and Identifiers'' field on the institutional claim form is to contain the National Provider Identifier (NPI) and name of the attending physician currently responsible for certifying the terminal illness and signing the individual's plan of care for medical care and treatment. If the patient does not have an attending physician that is a D.O. or M.D., the hospice would enter the NPI and name of the hospice medical director or physician member of the interdisciplinary group that certified that the patient is terminally ill. As outlined in the Medicare Claims Processing Manual, Section 30.3 of Chapter 11, the ''Other Provider Name and Identifiers'' field on the institutional claim form is to contain the NPI and name of attending physician if such attending provider is a nurse practitioner or physician assistant. In this case, the ''Attending Provider Name and Identifiers'' field would contain the NPI and name of the hospice medical director or physician member of the hospice interdisciplinary group that certified that the patient was terminally ill. When implementing claims processing edits to check for whether the attending physician (if an M.D. or D.O.) and hospice physician are enrolled or opted-out of Medicare, we would do so using PECOS, which can identify whether an NPI is associated with a nurse practitioner or physician assistant. If the NPI and name of a nurse practitioner or physician assistant appears in the ''Other Provider Name and Identifiers'' field on the institutional claim form, we would not deny the hospice claim if such nurse practitioner or physician assistant was not enrolled or opted-out of Medicare.

Comment: A commenter asked how our provision and the rationale for it relates to or impacts: (1) 42 CFR 405.455(b), which prevents Medicare Advantage (MA) plans from paying for services rendered by opted-out physicians; (2) the ''MA Hospice Carve-In''; and (3) the home health face-to-face requirement (HHFFR) in 42 CFR 424.22.

Response: Our provision is unrelated to MA or the HHFFR. Sections 424.507(a) and (b) only apply to Medicare Part A and Part B and do not pertain to MA payment. Too, whereas § 405.455(b) addresses services rendered by opt-out physicians, § 424.507(a) and (b) are restricted to the ordering/certifying/referring of services or items. As for the HHFFR, program integrity, like with our proposed provision, was a consideration in its promulgation. Yet the HHFFR is otherwise unrelated to the hospice enrollment/opt-out requirement. For instance, while § 424.507(b) will require enrollment/opt-out status for the hospice physician and the attending physician, satisfaction of the HHFFR under § 424.22 does not require the certifying physician or allowed practitioner (as that latter term is described in § 424.22) to be enrolled/opted-out.

Comment: A commenter asked whether there are any temporal limitations on certifications issued by an opted-out physician.

Response: Although we are somewhat unclear as to the commenter's precise question, we believe the commenter is inquiring whether a certification signed by a hospice physician or attending physician under § 418.22 that has opted-out is only valid for a certain period of time. Our proposal does not change any existing policies in § 418.22 with respect to the length of time for which a particular certification remains valid. It only addresses the required enrollment/opt-out status of the certifying physician and attending physician.

Comment: In a vein akin to the previous comment, several commenters sought clarification about two issues regarding the duration of the certification and benefit period. First, they asked whether the hospice physician and attending physician must be enrolled/opted-out for the entire benefit period attached to the certification/recertification. Second, they asked whether, if the certifying physician or attending physician later becomes unenrolled and non-opted-out, the hospice must obtain a new certification and, if so, whether this would impact the benefit period days and any associated face-to-face encounter timing.

Response: The hospice physician and attending physician need only be enrolled/opted-out at the time they make the certification or recertification. They need not remain enrolled/opted-out during the patient's entire certification and benefit period and, if they become unenrolled and non-opted-out, the hospice need not secure a new certification to replace the one the previously enrolled/opted-out physician signed.

Comment: Several commenters asked CMS to clarify that physicians who complete the Form CMS–855 enrollment application per our proposal would neither have to list ''Hospice and Palliative Medicine'' as their specialty designation (specialty code 17) nor specify ''Hospice'' as among the services they are delivering. They explained that some attending physicians do not routinely refer patients to hospice and may not anticipate being designated as a hospice attending physician when they complete the Medicare enrollment application.

Response: We agree with this comment to the extent it pertains to an attending physician under our proposal. For hospice physicians, however, and as with all physicians who complete the Form CMS–855, it is important that they accurately and truthfully disclose on the application their primary specialty. If the hospice physician's primary specialty is indeed hospice/palliative care, this must be reported.

Comment: Several commenters suggested that in lieu of our proposal, CMS should focus on other means of identifying potentially problematic hospices, such as: (1) identifying parties that own multiple independent hospices with different state licenses and National Provider Identifiers; and (2) hospices that are co-located within the same physical site. Other commenters stated that measures such as a moratorium on new hospice licenses in overserved areas and greater scrutiny of high-risk hospices would be more effective in stopping problematic hospices than requiring physician enrollment.

Response: We do not believe our efforts to address hospice program integrity and quality of care concerns need to reflect an ''either/or'' approach, whereby the adoption of one measure mandates the exclusion of another. There are multiple facets of the hospice arena that are concerning to us, and our hospice certifying proposal is directly aimed at ensuring that physicians who certify hospice services are adequately vetted and are confirmed to meet Medicare requirements. In other words, this precise concern of ours must be addressed via a specific measure, and there is no better means of doing so than our proposal.

Comment: A commenter asked CMS to identify in future rulemaking: (1) the volume of fraudulent hospice referrals from non-Medicare enrolled physicians; and (2) outline the administrative burden of this proposal on hospices and not merely physicians. This would allow stakeholders to furnish substantive feedback that could help CMS make informed policy decisions that improve program integrity without creating unnecessary barriers to services.

Response: We will update the regulatory impact analysis to include an estimate of the hour and cost burden our provision could have on hospices. As for the volume of fraudulent hospice certifications from unenrolled and non-opted-out physicians, our available information is mostly limited to enrolled parties. Nonetheless, the close scrutiny and screening the enrollment process furnishes has helped ensure that Medicare payments are only made to qualified providers and suppliers and, more pertinently, that DMEPOS, HHA, imaging, and clinical laboratory items and services are ordered/certified by physicians and practitioners who meet Medicare requirements. We believe this will be the case with our hospice provision, too.

Comment: A commenter urged CMS to ensure that hospices can ascertain a physician's enrollment or opt-out status as easily as possible. Although, the commenter noted, enrollment data may be available online, the ability to search such data should be as intuitive and streamlined as possible to limit burden on hospices.

Response: We agree. We note that the ORDF has given providers and suppliers a simple, expeditious means of confirming a physician's or practitioner's enrollment or opt-out status. We will work closely with the hospice community when implementing this provision and will furnish education and outreach, particularly regarding the matter of enrollment/opt-out status verification.

Comment: A commenter stated that our proposed requirement may not resolve concerns related to inappropriate certification and should be further considered before implementation to avoid adding barriers to care. The commenter explained that given the short-stay of many patients, it is important not to impose administrative steps that could delay care.

Response: As with all of our provider enrollment regulatory proposals, we carefully considered our hospice enrollment/opt-out provision before proposing it and believe it is the best means of closing the vulnerability of unscreened hospice physicians certifying hospice services. While we recognize that hospice stays are often short, we believe that most currently unenrolled/non-opted-out hospice physicians and attending physicians (both categories of which we believe, as previously mentioned, are very few) will enroll or opt-out per our requirements.

Comment: Several commenters did not believe our proposal would significantly aid in preventing hospice fraudulent behavior because false certifications will not be identified by the enrollment verification when claims are processed. They added that many fraudulent activities that CMS cited in the proposed rule (and highlighted by the OIG and media reports) involve parties other than physicians; for instance, the proposed rule identified activities such as paying recruiters to target ineligible beneficiaries and false certifications being part of wider fraud schemes orchestrated by hospice owners and operators, not by individual physicians.

Response: We note two things. One is that the principal purpose of the enrollment process is to prevent fraud from occurring in the first place by screening providers and suppliers before they enroll in Medicare and submit claims. Described otherwise, the aim is not to wait until claims are submitted to detect fraud but to keep fraudulent parties from participating in Medicare altogether. This reflects CMS' desire to avoid a ''pay-and-chase'' approach whereby we pay claims and, if we find fraud associated with that payment, attempt to recoup the monies and take action against the provider or supplier. By being proactive, we can stop such activity before it begins. This is the objective behind our hospice provision. Carefully screening hospice physicians and attending physicians (such as for felony convictions, sanctions, etc.) before they are able to certify Medicare hospice services will, we believe, significantly reduce the risk that problematic physicians will furnish false certifications. The second point is that while some hospice fraud schemes do not directly involve certifying physicians, some do. Indeed, we previously noted cases where physicians made false certifications. We also identified several instances of such conduct in the recently published CY 2024 Home Health Prospective Payment System proposed rule (88 FR 43654).[30] We stress that simply because a certain fraud scheme was devised by the hospice's owner or manager rather than the hospice physician does not excuse any participation therein by the latter.

Comment: A commenter requested that CMS create an exception to our requirement when the hospice makes a good-faith effort to determine but cannot confirm the enrollment status of the certifying or attending physician. The commenter stated this would prevent unnecessary delays to hospice election and care.

Response: We respectfully disagree. For reasons already outlined, we believe it is critical that hospice and attending certifying physicians be enrolled or opted-out. We also believe the ORDF will enable hospices to expeditiously ascertain the physician's enrollment/opt-out status. This has been the general experience of other Medicare providers and suppliers (such as HHAs) who must verify the enrollment/opt-out status of physicians and practitioners who order or certify the services or items referenced in § 424.507.

Comment: Several commenters asked whether CMS will update the ORDF to include a column for hospices (similar to the existing columns for DMEPOS and HHAs).

Response: We will update the file to accommodate hospices.

Comment: Commenters recommended that CMS provide education to physicians and hospices about the enrollment requirements, processes, list of services, and taxonomy codes relevant to our provision.

Response: CMS will indeed furnish extensive education to the hospice community and physicians on the matters the commenters' referenced.

5. Final Provisions

We are finalizing our hospice enrollment provisions as proposed, though the implementation date for these provisions will be May 1, 2024.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and

[30] ''Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements.''

approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of this rule that contain information collection requirements.

A. Hospice Certifying Physician Enrollment

As finalized in section III E. of this rule, physicians who certify hospice services for Medicare beneficiaries must be enrolled in or validly opted-out of Medicare as a prerequisite for payment of the hospice service in question. Most certifying physicians are already Medicare-enrolled or validly opted-out. Nonetheless, we noted in the proposed rule that, per CMS data, approximately 2,173 physicians who certify Medicare hospice services are not. These physicians, as already stated, would have to enroll or opt-out under our provision. However, we recently reconsidered this estimate and, based on the latest data, have determined that there are only 1,382 physicians who would have to enroll or opt-out pursuant to our requirement. We will use this figure in our final burden projections.

Strictly for purposes of establishing an estimate, we project that the average physician will complete a Form CMS–855O enrollment application (Medicare Enrollment Application—Registration for Eligible Ordering and Referring Physicians and Non-Physician Practitioners—OMB Control No.: 0938–1135) rather than an opt-out affidavit to comply with our requirements. Per previous estimates, it would take approximately 0.5 hours for a physician to complete the Form CMS–855O application.

According to the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2022 (see *http://www.bls.gov/oes/current/oes_nat.htm*), the mean hourly wage for the general category of ''Physicians, All Other'' is $114.76. With fringe benefits and overhead, the total per hour rate is $229.52. The foregoing wage figures are outlined in Table 8:

TABLE 8: National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Physicians, All Other	29-1216	114.76	114.76	229.52

We project that our provision will therefore result in a 691-hour burden (1,382 × 0.5 hr) at a cost of $158,598 (691 × $229.52). (Most of these physicians will enroll during the first year of our provision in order to continue certifying hospice services.) Averaged over the 3-year OMB-approval period, this results in annual burdens of 230 hours and $52,866. This burden will be updated as part of a separate Paperwork Reduction Act submission.

We received no comments on our proposed ICR estimates and are finalizing our revised projections as described.

B. Codification of HQRP Data Completeness Thresholds

The codifications to the HQRP data completeness thresholds reflects the same thresholds which have been applied to the HQRP since the FY 2018 Hospice Final Rule. As such, this rule does not impose any additional collection of information burden on hospices.

V. Regulatory Impact Analysis

A. Statement of Need

1. Hospice Payment

This final rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This rule updates the payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2024 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

2. Hospice Quality Reporting Program

Sections 1814(i)(5)(A) through (C) of the Act authorizes the HQRP which requires that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy will apply beginning with the FY 2024 annual payment update (APU) that is based on CY 2022 quality data. Specifically, the Act requires that, for FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

3. Impact of Hospice Ordering/Certifying Physician Enrollment

We proposed that physicians who certify hospice services must be enrolled in or opted-out of Medicare in order to do so. This proposal was needed so that CMS could screen the certifying physician to ensure that they are qualified to certify services (for

example, licensed, do not have adverse legal actions, etc.). Via this screening process, we can help protect beneficiaries and the Trust Funds from unqualified and problematic physicians.

B. Overall Impacts

1. Hospice Payment

We estimate that the aggregate impact of the payment provisions in this final rule would result in an estimated increase of $780 million in payments to hospices, resulting from the hospice payment update percentage of 3.1 percent for FY 2024. The impact analysis of this rule represents the projected effects of the changes in hospice payments from FY 2023 to FY 2024. Using the most recent complete data available at the time of rulemaking, in this case FY 2022 hospice claims data as of May 11, 2023, we simulate total payments using the FY 2023 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates and compare it to our simulation of total payments using FY 2022 utilization claims data, the FY 2024 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2023 wage index and payment rates for each level of care by the FY 2024 wage index and FY 2023 payment rates, we obtain a wage index standardization factor for each level of care. We apply the wage index standardization factors so that the aggregate simulated payments do not increase or decrease due to changes in the wage index.

Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 14094 on Modernizing Regulatory Review (April 6, 2023), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96 354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (CRA) (5 U.S.C. 804(2)).

Executive Orders 12866 (as amended by E.O. 14094) and E.O. 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 14094 amends 3(f) of Executive Order 12866 to define a ''significant regulatory action'' as an action that is likely to result in a rule that: (1) has an annual effect on the economy of $200 million or more in any 1 year, or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (2) creates a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially alters the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) of $200 million or more in any 1 year. Based on our estimates, OMB'S Office of Information and Regulatory Affairs has determined this rulemaking significant under section 3(f)(1) of E.O. 12866. Accordingly, we have prepared a regulatory impact analysis presents the costs and benefits of the rulemaking to the best of our ability.

C. Detailed Economic Analysis

1. Hospice Payment Update for FY 2024

The FY 2024 hospice payment impacts appear in Table 9. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size), and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows the effect of using the FY 2024 updated wage index data with a 5-percent cap on wage index decreases. This represents the effect of moving from the FY 2023 hospice wage index to the FY 2024 hospice wage index. The aggregate impact of the changes in column three is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2024 hospice wage index. The fourth column shows the effect of the hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act and is consistent for all providers. The hospice payment update percentage of 3.1 percent is based on the 3.3 percent inpatient hospital market basket percentage increase, reduced by a 0.2 percentage point productivity adjustment. The fifth column shows the total effect of the updated wage data and the hospice payment update percentage on FY 2024 hospice payments but does not include the effect of moving from the 2 percent reduction to the 4 percent reduction for failure to report quality data. It is projected aggregate payments would increase by 3.1 percent; assuming hospices do not change their billing practices. As illustrated in Table 9, the combined effects of all the proposals vary by specific types of providers and by location. We note that simulated payments are based on utilization in FY 2022 as seen on Medicare hospice claims (accessed from the CCW on May 11, 2023) and only include payments related to the level of care and do not include payments related to the service intensity add-on.

As illustrated in Table 9, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 9: Impact to Hospices for FY 2024

Hospice Subgroup	Hospices	FY 2024 Updated Wage Data	FY 2024 Hospice Payment Update (%)	Overall Total Impact for FY 2024
All Hospices	5,653	0.0%	3.1%	3.1%
Hospice Type and Control				
Freestanding/Non-Profit	559	-0.1%	3.1%	3.0%
Freestanding/For-Profit	4,013	0.0%	3.1%	3.1%
Freestanding/Government	38	-0.4%	3.1%	2.7%
Freestanding/Other	371	0.2%	3.1%	3.3%
Facility/HHA Based/Non-Profit	328	-0.1%	3.1%	3.0%
Facility/HHA Based/For-Profit	187	-0.4%	3.1%	2.7%
Facility/HHA Based/Government	72	0.2%	3.1%	3.3%
Facility/HHA Based/Other	85	0.0%	3.1%	3.1%
Subtotal: Freestanding Facility Type	4,981	0.0%	3.1%	3.1%

Subtotal: Facility/HHA Based Facility Type	672	-0.1%	3.1%	3.0%
Subtotal: Non-Profit	887	-0.1%	3.1%	3.0%
Subtotal: For Profit	4,200	0.0%	3.1%	3.1%
Subtotal: Government	110	-0.1%	3.1%	3.0%
Subtotal: Other	456	0.2%	3.1%	3.3%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	127	-0.3%	3.1%	2.8%
Freestanding/For-Profit	354	-0.3%	3.1%	2.8%
Freestanding/Government	22	-0.8%	3.1%	2.3%
Freestanding/Other	55	-0.2%	3.1%	2.9%
Facility/HHA Based/Non-Profit	126	-0.4%	3.1%	2.7%
Facility/HHA Based/For-Profit	51	-0.1%	3.1%	3.0%
Facility/HHA Based/Government	56	-0.2%	3.1%	2.9%
Facility/HHA Based/Other	47	-0.3%	3.1%	2.8%
Hospice Type and Control: Urban				
Freestanding/Non-Profit	432	-0.1%	3.1%	3.0%
Freestanding/For-Profit	3,659	0.0%	3.1%	3.1%
Freestanding/Government	16	-0.3%	3.1%	2.8%
Freestanding/Other	316	0.3%	3.1%	3.4%
Facility/HHA Based/Non-Profit	202	0.0%	3.1%	3.1%
Facility/HHA Based/For-Profit	136	-0.5%	3.1%	2.6%
Facility/HHA Based/Government	16	0.4%	3.1%	3.5%
Facility/HHA Based/Other	38	0.1%	3.1%	3.2%
Hospice Location: Urban or Rural				
Rural	838	-0.3%	3.1%	2.8%
Urban	4,815	0.0%	3.1%	3.1%
Hospice Location: Region of the Country (Census Division)				
New England	152	-0.7%	3.1%	2.4%
Middle Atlantic	284	0.5%	3.1%	3.6%
South Atlantic	608	0.3%	3.1%	3.4%
East North Central	592	-0.5%	3.1%	2.6%
East South Central	255	0.0%	3.1%	3.1%
West North Central	420	-0.1%	3.1%	3.0%
West South Central	1,104	0.2%	3.1%	3.3%
Mountain	591	-0.5%	3.1%	2.6%
Pacific	1,598	0.1%	3.1%	3.2%
Outlying	49	-1.6%	3.1%	1.5%
Hospice Size				
0 – 3,499 RHC Days (Small)	1,422	0.1%	3.1%	3.2%
3,500-19,999 RHC Days (Medium)	2,554	-0.1%	3.1%	3.0%
20,000+ RHC Days (Large)	1,677	0.0%	3.1%	3.1%

Source: FY 2022 hospice claims data from CCW accessed on May 11, 2023.

Note: The overall total impact reflects the addition of the individual impacts, which includes the wage index impact as well as the 3.1 percent hospice payment update percentage. However, it does not include the effect of moving from the 2 percent reduction to the 4 percent reduction for failure to report quality data.

Region Key:
New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central=Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas
Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific= Alaska, California, Hawaii, Oregon, Washington

2. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review this rule, we assume that the total number of unique commenters on this year's proposed rule will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed this year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we believe that the number of past commenters would be a fair estimate of the number of reviewers of this final rule. We welcomed public comments on the approach in estimating the number of entities that would review the proposed rule. We did not receive any public comments specific to our solicitation.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We sought public comments on this assumption, and we did not receive any public comments.

Using the occupational wage information from the BLS for medical and health service managers (Code 11–9111) from May 2022; we estimate that the cost of reviewing this rule is $115.22 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes119111.htm*). This final rule consists of approximately 32,000 words. Assuming an average reading speed of 250 words per minute, it would take approximately 2 hours for staff to review half of it. For each hospice that reviews the rule, the estimated cost is $230.44 (2 hours × $115.22). Therefore, we estimate that the total cost of reviewing this regulation is $8,756.72 ($115.22 × 76 reviewers).

3. Impacts for the Hospice Quality Reporting Program for FY 2024

The HQRP requires the active collection under OMB control number #0938–1153 (CMS 10390; expiration 02/29/2024) of the Hospice Items Set (HIS) and CAHPS® Hospice Survey (OMB control number 0938–1257 (CMS–10537; expiration 12/31/2023). Failure to submit data required under section 1814(i)(5) of the Act with respect to a CY will result in the reduction of the annual hospice market basket percentage increase otherwise applicable to a hospice for that calendar year. From FY 2014 through FY 2023, hospices that failed to report quality data had their market basket percentage increase reduced by 2 percentage points. As noted in section C.5. of this final rule, section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 (Pub. L. 116–260) to change the payment reduction for failing to meet hospice quality reporting requirements to 4 percentage points, beginning with FY 2024. This section analyzes the estimated impact of the transition from 2 percentage points to 4 percentage points.

Based on historical performance trends, we estimate that roughly 18.4 percent of hospices (an estimated 1,049 out of approximately 5,700 active hospices) will fail to receive the full annual percentage increase in FY 2024, if active Medicare-certified hospices perform similarly in CY 2022 to hospice performance in previous years. We project that the 4 percentage point penalty for hospices will represent approximately $82.4 million in hospice payment dollars during the reporting period, out of an estimated total $23.9 billion paid to all hospices. The net impact of the policy change from 2 percent APU penalty to 4 percent APU penalty is estimated to be $41.2 million.

4. Impact of Hospice Certifying Physician Enrollment

We believe there will be two main impacts of this provision. The first is the ICR burden outlined in section IV of this rule regarding the completion of the Form CMS–855O, which we projected to be 691 hours and $158,598 over a 3-year period, or 230 hours or $52,866 per year. The second involves the burden the hospice will incur in verifying the physician's enrollment/opt-out status. There are approximately 6,712 Medicare-enrolled hospices. Based on our experience with providers and suppliers such as HHAs and DMEPOS suppliers, we believe it will take a hospice approximately 5 minutes to confirm the enrollment/opt-out status of the certifying physician(s). Solely for purposes of establishing a projection, we will estimate that there are roughly 1.7 million Medicare hospice beneficiaries per year (or, on average, 253 per hospice) (1.7 million/6,712), this results in an annual hour burden of 141,455 hours (6,712 × 253 × 0.0833). In terms of cost, we believe that the hospice's administrative personnel will typically confirm the physician's enrollment/opt-out status. Consequently, we will use the following wage category and hourly rate from the BLS May 2022 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*):

TABLE 10: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Office and Administrative Support Workers, All Other	43-9199	20.75	20.75	41.50

This results in an estimated annual cost of $5,870,383 ($141,455 × $41.50).

D. Alternatives Considered

1. Hospice Payment

Since the hospice payment update percentage is determined based on statutory requirements at section 1814(i)(1)(C) of the Act, we did not consider updating the hospice payment rates by the payment update percentage. The 3.1 percent hospice payment update percentage for FY 2024 is based on a 3.3 percent inpatient hospital market basket percentage increase for FY 2024, reduced by a 0.2 percentage point productivity adjustment. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage increase for that FY. Section 3401(g) of the Affordable Care Act also mandates that, starting with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

2. Hospice Quality Reporting Program

We did not consider any alternatives in this final rule.

3. Hospice Physician Enrollment

We did not consider any alternatives to our proposal to require physicians who certify hospice services for Medicare beneficiaries to be enrolled/opted-out as a prerequisite for the payment of the hospice service in question. This is because the enrollment process is the only available, feasible means of ascertaining the physician's compliance with all applicable requirements and whether he or she has any adverse legal history.

E. Accounting Statement

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), in Table 11, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 11 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this rule. This estimate is based on the data for 5,653 hospices in our impact analysis file, which was constructed using FY 2022 claims (accessed from the CCW on May 11, 2023). All expenditures are classified as transfers to hospices.

TABLE 11: Accounting Statement
Classification of Estimated Transfers and Costs, From FY 2023 to FY 2024

Category	Transfers
Annualized Monetized Transfers	$780 million*
From Whom to Whom?	Federal Government to Medicare Hospices
Category	**Costs**
Annualized Monetized Costs Associated with Changes in APU Reductions due to Data Submission Requirements	$41.2 million**

*The increase of $780 million in transfer payments is a result of the 3.1 percent hospice payment update compared to payments in FY 2023.

**The $41.2 million is the amount CMS is projected to recoup based on the increased penalty for hospices that fail to meet HQRP data submission requirements, Compared to APU penalties in FY 2023.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. We consider all hospices as small entities as that term is used in the RFA. The North American Industry Classification System (NAICS) was adopted in 1997 and is the current standard used by the Federal statistical agencies related to the U.S. business economy. There is no NAICS code specific to hospice services. Therefore, we utilized the NAICS U.S. industry title ''Home Health Care Services'' and corresponding NAICS

code 621610 in determining impacts for small entities. The NAICS code 621610 has a size standard of $19 million.[31] Table 12 shows the number of firms, revenue, and estimated impact per home health care service category.

TABLE 12: NUMBER OF FIRMS, REVENUE, AND ESTIMATED IMPACT OF HOME HEALTH CARE SERVICES BY NAICS CODE 621610

NAICS Code	NAICS Description	Enterprise Size	Number of Firms	Receipts ($1,000)	Estimated Impact ($1,000) per Enterprise Size
621610	Home Health Care Services	<100	5,861	210,697	$35.95
621610	Home Health Care Services	100-499	5,687	1,504,668	$264.58
621610	Home Health Care Services	500-999	3,342	2,430,807	$727.35
621610	Home Health Care Services	1,000-2,499	4,434	7,040,174	$1,587.77
621610	Home Health Care Services	2,500-4,999	1,951	6,657,387	$3,412.29
621610	Home Health Care Services	5,000-7,499	672	3,912,082	$5,821.55
621610	Home Health Care Services	7,500-9,999	356	2,910,943	$8,176.81
621610	Home Health Care Services	10,000-14,999	346	3,767,710	$10,889.34
621610	Home Health Care Services	15,000-19,999	191	2,750,180	$14,398.85
621610	Home Health Care Services	≥20,000	961	51,776,636	$53,877.87
621610	Home Health Care Services	Total	23,801	82,961,284	$3,485.62

Source: Data obtained from United States Census Bureau table "us_6digitnaics_rcptsize_2017" (SOURCE: 2017 County Business Patterns and Economic Census) Release Date: 5/28/2021: https://www2.census.gov/programs-surveys/susb/tables/2017/
Notes: Estimated impact is calculated as Receipts ($1,000)/Number of firms.

The Department of Health and Human Services practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The majority of hospice visits are Medicare paid visits and therefore the majority of hospice's revenue consists of Medicare payments. Based on our analysis, we conclude that the policies finalized in this rule would result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of hospices. Therefore, the Secretary has certified that this hospice final rule would have significant economic impact on a substantial number of small entities. We estimate that the net impact of the policies in this rule is a 3.1 percent or approximately $780 million in increased revenue to hospices in FY 2024. The 3.1 percent increase in expenditures when comparing FY 2023 payments to estimated FY 2024 payments is reflected in the last column of the first row in Table 9 and is driven solely by the impact of the hospice payment update percentage reflected in the fourth column of the impact table. In addition, small hospices would experience a greater estimated increase (3.2 percent), compared to large hospices (3.1 percent) due to the updated wage index. Further detail is presented in Table 9, by hospice type and location.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a MSA and has fewer than 100 beds. This rule will only affect hospices. Therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals (see Table 12).

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $177 million or more in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. We have reviewed this rule under these criteria of Executive Order 13132 and have determined that it will not impose substantial direct costs on state or local governments.

I. Conclusion

We estimate that aggregate payments to hospices in FY 2024 will increase by $780 million as a result of the hospice payment update, compared to payments in FY 2023. We estimate that in FY 2024, hospices in urban areas will experience, on average, a 3.1 percent increase in estimated payments compared to FY 2023; while hospices in rural areas will experience, on average, a 2.8 percent increase in estimated payments compared to FY 2023. Hospices providing services in the Middle Atlantic and South Atlantic regions would experience the largest estimated increases in payments of 3.6 percent and 3.4 percent, respectively. Hospices serving patients in areas in the Outlying regions would experience, on

[31] *https://www.sba.gov/sites/sbagov/files/2023-03/Table%20of%20Size%20Standards_Effective%20March%2017%2C%202023%20%281%29%20%281%29_0.pdf.*

average, the lowest estimated increase of 1.5 percent in FY 2024 payments.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 25, 2023.

List of Subjects

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Health facilities, Health professions, Medicare Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below.

PART 418—HOSPICE CARE

■ 1. The authority citation for part 418 continues to read as follows:

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

■ 2. Amend § 418.22 by revising paragraph (a)(4)(ii) to read as follows:

§ 418.22 Certification of terminal illness.

* * * * *

(a) * * *

(4) * * *

(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]

■ 3. Amend § 418.204 by removing paragraph (d).

§ 418.309 [Amended]

■ 4. 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''.

■ 5. Amend § 418.312 by adding paragraph (j) to read as follows

§ 418.312 Data submission requirements under the hospice quality reporting program

* * * * *

(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:

* * * * *

(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.

* * * * *

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2023–16116 Filed 7–28–23; 4:15 pm]

BILLING CODE 4120–01–P