**FY2024 Hospice Rule Proposes 2.6% Update**

March 28, 2024

* **Requests Info on Payment for Expensive Palliative Treatments**
* **Updates Geographic Classifications**
* **Proposes Implementation of the HOPE**
* **Revised CAHPS Hospice Survey**
* **Other Quality Reporting Program Updates**
* **Request for Information (RFI) Regarding Future HQRP Social Determinants of Health (SDOH) Items**
* **Scroll down for quotes/analysis from NAHC’s Bill Dombi, Davis Baird, and Katie Wehri**

On Thursday, March 28, 2023, the Centers for Medicare & Medicaid Services (CMS) issued the [Fiscal Year (FY) 2025 Hospice Payment Rate Update Proposed Rule (CMS-1810-P)](https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2025-hospice-payment-rate-update-proposed-rule-cms-1810-p).

* Fact Sheet [HERE](https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2025-hospice-payment-rate-update-proposed-rule-cms-1810-p)
* Proposed rule text [HERE](https://public-inspection.federalregister.gov/2024-06921.pdf)

The rule contains the following provisions and updates:

* A proposed annual payment update of 2.6% (an estimated increase of $705 million in payments from FY 2024), and proposed updates to the hospice wage index and the aggregate cap
	+ *NAHC is disappointed in this small update percentage. It does not adequately reflect the increased costs and resource intensity resulting from ongoing workforce shortages and inflationary pressures. As the seminal NORC analysis showed, utilization of the hospice benefit saves the overall Medicare program billions of dollars a year – CMS needs to recognize this dynamic value and provide appropriate and sufficient payment updates that encourage and support greater access to high-quality hospice care.*
* The proposed hospice cap amount for the 2025 fiscal year is $34,364.85
* A Request for Information to solicit comments regarding implementing a separate payment mechanism to account for high-intensity palliative care services (i.e., palliative dialysis, chemotherapy, radiation, and transfusions) provided under the hospice benefit.
* A proposal to adopt the most recent OMB statistical area geographic delineations, which revise the existing core-based statistical areas (CBSAs) based on data collected during the 2020 Decennial Census
	+ This proposed change to the geographic delineations will have impacts on the payment rates hospices receive, based on their locations.
	+ Hospices affected by the change to their geographic wage index will be eligible for applying a 5% cap on any decrease to the wage index from the prior year. This permanent cap, finalized in the FY 2023 Hospice Final Rule, would prevent a geographic area’s wage index from falling below 95% of its wage index calculated in the prior FY. For FY 2025, CMS believes that the permanent 5% cap on wage index decreases would be sufficient to mitigate any potential negative impact for hospices serving beneficiaries in areas that are impacted by the proposal to adopt the revised OMB delineations and that no further transition is necessary.
	+ Previously, the 5% cap had been applied at the CBSA or statewide rural area level, meaning that all the counties that make up the CBSA or rural area received the 5% cap. However, for FY 2025, to mitigate any potential negative impact caused by CMS’ proposed adoption of the revised delineations, they propose that in addition to the 5% cap being calculated for an entire CBSA or statewide rural area, the cap would also be calculated at the county level, so that individual counties moving to a new delineation would not experience more than a 5%decrease in wage index from the previous fiscal year.
* CMS is moving its annual hospice utilization data updates (normally found in each year’s proposed rule) to a new location on CMS’ website, which is where these updates will be posted going forward for future years as well <https://www.cms.gov/medicare/payment/fee-for-serviceproviders/hospice> (*please note that at the time of writing, the utilization data had not been uploaded to this CMS webpage*)
* CMS proposed implementation of the Hospice Outcomes & Patient Evaluation (HOPE) tool which was expected. It also proposes two new HOPE-based quality measures.
* A revised CAHPS Hospice Survey.
* Request for Information (RFI) Regarding Future HQRP Social Determinants of Health (SDOH) Items

“While the proposed rule may appear to be fairly innocuous,”said NAHC President William A. Dombi, in response to the rule announcment, “the hospice community should pay attention to the information request on high cost services as it may signal an emerging interest in payment model reform.

“What is missing is also notable,” continued Dombi. “CMS has not proposed any program integrity measures to address continued concerns on the surge in hospice growth in certain parts of the country despite the warning signs presented.”

NAHC Vice President for Hospice Policy Davis Baird said “NAHC is disappointed in the inadequate 2.6% payment rate update proposed by CMS. This small increase does not reflect the high costs hospices continue to face as a result of ongoing workforce shortages and inflationary cost challenges. More and more people are being served by hospice every year, and  CMS needs to recognize the dynamic value the benefit provides – not only from the improved quality of life hospices provide, but also from the huge financial savings to Medicare that utilization of the hospice benefit drives. As the seminal NORC analysis showed, hospice saves the overall Medicare program billions of dollars a year. It is high time CMS acknowledges this outsized impact and provides the resources hospices need to meet the growing demand for their unique services.”



“NAHC is pleased that CMS is proposing regulatory text changes to clarify points of confusion pertaining to which physicians are able to certify terminal illness and around the election statement and notice of election,” said Katie Wehri, NAHC’s Director of Home Health and Hospice Regulatory Affairs. “The quality reporting program proposal that is already generating great interest is the proposal to implement the HOPE and the release of the draft HOPE tool and accompanying guidance manual. While hospices have been requesting changes to the CAHPS Hospice Survey and will be happy to see some of these proposals, more work needs to be done to address the decreasing response rate and reasons for this.”

Following is a summary of the proposed rule as developed by NAHC staff:

**PROPOSED FY2024 HOSPICE PAYMENT UPDATE PERCENTAGE**

The proposed hospice payment update percentage for FY 2025 is **2.6%** (an estimated increase of $705 million in payments from FY 2024). This update is based on the proposed inpatient hospital market basket update of 3.0% minus a productivity adjustment currently estimated at 0.4 percentage points.

It should be noted that the hospital market basket update and the productivity adjustment values are subject to change and will likely be adjusted in the final hospice payment rule which will be issued this summer.

[Table 20](https://public-inspection.federalregister.gov/2024-06921.pdf#page=103) in the rule contains the estimated *combined* payment update effects of *all* the rule’s proposals, broken down by specific type of provider and by location (ie for-profit vs not-for-profit; rural vs urban, etc).

**REQUEST FOR INFORMATION (RFI) ON PAYMENT MECHANISM FOR HIGH INTENSITY PALLIATIVE CARE SERVICES**

CMS states in the rule that beneficiary populations with complex palliative needs and potentially high-cost medical care needs face barriers when accessing hospice care. These barriers may result in an underuse of the hospice benefit, despite its demonstrated potential to both improve quality of care and lower costs. CMS states that there is a subset of hospice eligible beneficiaries that would likely benefit from receiving palliative, rather than curative, chemotherapy, radiation, blood transfusions, and dialysis.

In the FY2024 hospice proposed rule, CMS released an RFI that, in part, sought to gather information from the stakeholder community on the nature of these higher-level and higher-cost palliative treatments, and how hospices think about and implement them in their clinical and operational practices. NAHC responded to that RFI in [our comments on the FY2024 rule](https://downloads.regulations.gov/CMS-2023-0051-0060/attachment_1.pdf). Aligned with the NAHC comments, in this new proposed rule, CMS indicates that “*commenters stated that providing complex palliative treatments and higher intensity levels of hospice care may pose financial risks to hospices when enrolling such patients. Commenters stated that the current bundled per diem payment is not reflective of the increased expenses associated with higher-cost and certain patient subgroups”.*

**CMS is looking to gather additional information on this issue, and sets out the following RFI questions**, which NAHC will work closely with our members to develop responses to:

1. *What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?*
* *What specific financial risks or costs are of particular concern to hospices that would prevent the provision of higher-cost palliative treatments when appropriate for some beneficiaries? Are there individual cost barriers which may prevent a hospice from providing higher-cost palliative care services? For example, is there a cost barrier related to obtaining the appropriate equipment (for example, dialysis machine)? Or is there a cost barrier related to the treatment itself (for example, obtaining the necessary drugs or access to specialized staff)?*
* *Should there be any parameters around when palliative treatments should qualify for a different type of payment? For example, we are interested in understanding from hospices who do provide these types of palliative treatments whether the patient is generally in a higher level of care (CHC, GIP) when the decision is made to furnish a higher-cost palliative treatment? Should an additional payment only be applicable when the patient is in RHC?*
* *Under the hospice benefit, palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). In addition to this definition of palliative care, should CMS consider defining palliative services, specifically regarding high-cost treatments? (Note, CMS is not seeking a change to the definition of palliative care but rather should CMS consider defining palliative services with regard to high-cost treatments?)*
* *Should there be documentation that all other palliative measures have been exhausted prior to billing for a payment for a higher-cost treatment? If so, would that continue to be a barrier for hospices?*
* *Should there be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment that would exceed the per-diem rate?*

**PROPOSED FY 2025 HOSPICE WAGE INDEX**

For FY 2025, CMS is proposing that the proposed hospice wage index would be based on the FY 2025 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021 (FY 2021 cost report data). The proposed FY 2025 hospice wage index would also include the 5% cap on wage index decreases (finalized in the FY 2023 Hospice Wage Index final rule). 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 2023 Hospice Wage Index final rule (87 FR 45673), CMS finalized for FY 2023 and subsequent years, the application of a permanent 5% 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%of its wage index calculated in the prior FY.

**PROPOSED FY 2025 HOSPICE PAYMENT RATES**

Following are the proposed hospice payment rates based on the estimated payment update percentage referenced above. The rates must be further adjusted by the wage index values to determine the rates a hospice will receive. (Please seethe proposed rule for further explanation of the SIA Budget Neutrality Factor and the Wage Index Standardization Factor.)

*Routine Home Care (RHC) rates:*



*Continuous Home Care (CHC), General Inpatient Care (GIP), and Inpatient Respite Care (IRC) rates:*



\*\*The service-intensity add-on (SIA) payment hourly rate will be equal to the CHC daily rate divided by 24

Please note that, as enacted as part of the Consolidated Appropriations Act of 2024, starting in FY2024, hospices failing to comply with the HQRP reporting requirements were subject to a 4% reduction in payments. This 4% penalty is in place for FY2025 and all subsequent years. Please see the proposed rule for [a table](https://public-inspection.federalregister.gov/2024-06921.pdf#page=40) reflecting the proposed reduced rates for those hospices.

**PROPOSED HOSPICE CAP AMOUNT FOR FY2024**

The proposed hospice cap amount for the FY202 cap year is **$34,364.85**. As with the payment rates, the cap amount is subject to change.

**PROPOSED IMPLEMENTATION OF NEW LABOR MARKET DELINEATIONS**

On July 21, 2023, the Office of Management and Budget (OMB) issued [Bulletin No. 23-01](https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf), which establishes revised delineations for the metropolitan statistical area (MSAs), Micropolitan Statistical Areas, Combined Statistical Areas, and Metropolitan Divisions, collectively referred to as Core Based Statistical Areas (CBSAs). **CMS is proposing to implement the new OMB delineations for the hospice wage index effective beginning in FY 2025.**Historically, CMS has adopted the latest OMB delineations in subsequent rulemaking after a new OMB Bulletin is released.

The new delineations contain a number of significant changes. For example, there are new CBSAs, urban counties that have become rural, rural counties that have become urban, and existing CBSAs that have been split apart. CMS believes it is important for the hospice wage index to use the latest OMB delineations available “*in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. We [CMS] further believe that using the most current OMB delineations would increase the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels*.”

*Proposed Transition Period for the Geographic Classification Changes; Applying the 5% Cap on Wage Index Decreases at a County Level (in addition to at the CBSA level)*

In the past, CMS has provided for transition periods when adopting changes that have significant payment implications, particularly large negative impacts, in order to mitigate the potential impacts of proposed policies on hospices. In the FY 2023 hospice final rule, CMS adopted a permanent 5% cap on wage index decreases beginning in FY 2023 and each subsequent year (87 FR 45677). The policy applies a permanent 5% 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% of its wage index calculated in the prior FY.

**For FY 2025, CMS believes that the permanent 5% cap on wage index decreases would be sufficient to mitigate any potential negative impact for hospices serving beneficiaries in areas that are impacted by the proposal to adopt the revised OMB delineations and that no further transition is necessary.**

Previously, the 5% cap had been applied at the CBSA or statewide rural area level, meaning that all the counties that make up the CBSA or rural area received the 5% cap. However, **for FY 2025, to mitigate any potential negative impact caused by CMS’ proposed adoption of the revised delineations, they propose that in addition to the 5% cap being calculated for an entire CBSA or statewide rural area, the cap would also be calculated at the county level, so that individual counties moving to a new delineation would not experience more than a 5% decrease in wage index from the previous fiscal year.** Specifically, CMS is proposing for FY 2025, that the 5% cap would also be applied to counties that would move from a CBSA or statewide rural area with a higher wage index value into a new CBSA or rural area with a lower wage index value, so that the county’s FY 2025 wage index would not be less than 95 percent of the county’s FY 2024 wage index value under the old delineation despite moving into a new delineation with a lower wage index.

*Wage Index Transition Code:*

Due to the way that CMS proposes to calculate the 5% cap for counties that experience an OMB designation change, some CBSAs and statewide rural areas could have more than one wage index value because of the potential for their constituent counties to have different wage index values as a result of application of the 5% cap. Specifically, some counties that change OMB designations would have a wage index value that is different than the wage index value assigned to the other constituent counties that make up the CBSA or statewide rural area that they are moving into because of the application of the 5% cap. However, for hospice claims processing, each CBSA or statewide rural area can have only one wage index value assigned to that CBSA or statewide rural area.

Therefore, hospices that serve beneficiaries in a county that would receive the cap would need to use a number other than the CBSA or statewide rural area number to identify the county’s appropriate wage index value for hospice claims in FY 2025**. CMS is proposing that beginning in FY 2025, counties that have a different wage index value than the CBSA or rural area into which they are designated after the application of the 5% cap would use a wage index transition code. These special codes are five digits in length and begin with “50**.” The 50XXX wage index transition codes would be used only in specific counties; counties located in CBSAs and rural areas that do not correspond to a different transition wage index value will still use the CBSA number.

The counties that will require a transition code and the corresponding 50XXX codes are shown in [Table 8](https://public-inspection.federalregister.gov/2024-06921.pdf#page=33) in the rule and will also be shown in the last column of the [FY 2025 hospice wage index file](https://www.cms.gov/files/zip/fy-2025-proposed-hospice-wage-index.zip).

*Micropolitan Statistical Areas:*

Overall, there are the same number of Micropolitan Areas (542) under the new OMB delineations based on the 2020 Census as there were using the 2010 Census (Micropolitan Areas are defined as a CBSA with at least one Urban Area that has a population of at least 10,000, but less than 50,00). CMS notes, however, that a number of urban counties have switched status and have joined or became Micropolitan Areas, and some counties that once were part of a Micropolitan Area, and thus were treated as rural, have become urban based on the 2020 Decennial Census data. CMS believes that the best course of action would be to continue our established policy and include Micropolitan Areas in each State’s rural wage index as these areas continue to be defined as having relatively small urban cores (populations of 10,000 to 49,999). Therefore, **in conjunction with our proposal to implement the new OMB labor market delineations beginning in FY 2025, and consistent with the treatment of Micropolitan Areas under the IPPS, we are also proposing to continue to treat Micropolitan Areas as ‘‘rural’’ and to include Micropolitan Areas in the calculation of each State’s rural wage index.**

*Urban Counties That Would Become Rural:*

Under the revised OMB statistical area delineations a total of 53 counties (and county equivalents) that are currently considered urban would be considered rural beginning in FY 2025. [Table 3](https://public-inspection.federalregister.gov/2024-06921.pdf#page=19) in the proposed rule lists the 53 counties that would become rural if CMS adopts as final their proposal to implement the revised OMB delineations.

*Rural Counties That Would Become Urban:*

Under the revised OMB statistical area delineations, a total of 54 counties (and county equivalents) that are currently located in rural areas would be considered located in urban areas under the revised OMB delineations beginning in FY 2025. [Table 4](https://public-inspection.federalregister.gov/2024-06921.pdf#page=21) in the rule lists the 54 counties that would be urban if CMS adopt as final their proposal to implement the revised OMB delineations.

*Urban Counties That Would Move to a Different Urban CBSA Under the Revised OMB Delineations*:

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to a new or existing urban CBSA under CMS’ proposal to adopt the revised OMB delineations. In other cases, applying the new OMB delineations would involve a change only in CBSA name or number, while the CBSA would continue to encompass the same constituent counties. [Table 5](https://public-inspection.federalregister.gov/2024-06921.pdf#page=23) in the rule lists CBSAs that would change in name and/or CBSA number only, but the constituent counties would not change (except in instances where an urban county became rural, or a rural county became urban.

In some cases, all the urban counties from a FY 2024 CBSA would be moved and subsumed by another CBSA in FY 2025. [Table 6](https://public-inspection.federalregister.gov/2024-06921.pdf#page=24) in the rule lists the CBSAs that, under CMS’ proposal to adopt the revised OMB statistical area delineations, would be subsumed by another CBSA.

In other cases, if CMS adopts the new OMB delineations, some counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. In another type of change, some CBSAs have counties that would split off to become part of or to form entirely new labor market areas. In some cases, a CBSA would lose counties to another existing CBSA if CMS adopts the new OMB delineations. [Table 7](https://public-inspection.federalregister.gov/2024-06921.pdf#page=25) in the rule lists the 73 urban counties that would move from one urban CBSA to a new or modified urban CBSA if CMS adopts the revised OMB delineations.

**CLARIFYING REGULATION TEXT CHANGES**

*Medical Director Condition of Participation*

Discrepancies exist between the Medical Director Condition of Participation (CoP) at § 418.102 and the payment requirements for the “certification of the terminal illness” and the “admission to hospice care” at § 418.22 and § 418.25, respectively. CMS proposes clarifying regulation text changes.  Specifically, statute provides that the medical director of the hospice or the physician member of the hospice interdisciplinary group can certify the patient’s terminal illness.  However, some of the regulatory citations do include both physician types.  And, the medical director designee (takes the place of the medical director when the medical director is not available) is also not consistently included. CMS would revise the text of the regulations to include the medical director, or physician designee if the medical director is not available, or physician member of the IDG among the specified physicians who may review the clinical information and certify and recertify the terminal illness. This does not connote a change in policy but allows for greater clarity and consistency between key components of hospice regulations and policies.

*Election of Hospice Care*

When discussing hospice election, stakeholders (such as Medicare contractors, medical reviewers, and hospices) often conflate the terms “election statement” and “NOE” (Notice of Election).  NAHC and hospice stakeholders have asked CMS to make it clear that these are two separate and distinct documents intended for separate purposes under the Medicare Hospice Benefit.  We are pleased that CMS is proposing to do this by reorganizing the language to clearly denote the differences between the election statement and the NOE. Specifically, CMS is proposing to title § 418.24(b) as “Election Statement” and would include the title “Notice of Election” at § 418.24(e). By clearly titling this section, the requirements for the election statement and the notice of election would be distinguished from one another, mitigating any confusion between the two documents.

This reorganization would not be a change in policy, rather it is intended to more clearly identify the requirements for the election statement and the NOE by reorganizing the structure of the regulations. CMS stresses the importance for stakeholders to fully understand that the election statement is required as acknowledgement of a beneficiary’s understanding of the decision to elect hospice and filed with the hospice, whereas the NOE is required for claims processing purposes and filed with the hospice MAC within five calendar days after the effective date of the election statement.

As NAHC has shared previously, one of the top payment denial reasons for hospices is an incomplete election statement. A complete election statement containing all required elements as set forth at § 418.24(b) is a condition for payment. CMS emphasizes the importance of each element in informing the beneficiary of their coverage when choosing to elect the Medicare hospice benefit and continues to encourage hospice agencies to utilize the [“Model Example of Hospice Election Statement”](https://www.cms.gov/files/document/model-example-hospice-election-statement-march-2024.pdf) .

**CMS is inviting comments on the clarifying regulation text changes and reorganization.**

**HOSPICE QUALITY REPORTING PROGRAM**

*Proposal of Two New Quality Measures*

**CMS proposes adding two process measures no sooner than CY 2027 to the HQRP calculated from data collected from the Hospice Outcomes & Patient Evaluation tool (HOPE):**

* **Timely Reassessment of Pain Impact and**
* **Timely Reassessment of Non-Pain Symptom Impact**

The proposed Timely Reassessment of Pain Impact process measure will determine how many patients assessed with moderate or severe pain impact were reassessed by the hospice within two calendar days, and the proposed Timely Reassessment of Non-Pain Symptom Impact process measure will determine how many patients assessed with moderate or severe non-pain impact were reassessed by the hospice within two calendar days. Compared to the single existing HQRP measure that includes pain symptom assessment, CMS believes the two proposed HOPE-based process measures will better reflect hospices’ efforts to alleviate patients’ symptoms on an ongoing basis.

These two measures would determine whether a follow-up visit occurs within 48 hours of an initial assessment of moderate or severe symptom impact.Both the process measures based on HOPE data will be calculated using assessments collected at admission or the HOPE Update Visit (HUV) timepoints. Pain symptom severity and impact will be determined based on hospice patients’ responses to the pain symptom impact data elements within HOPE. Non-pain symptom severity and impact will be determined based on patients’ responses to the HOPE data elements related to shortness of breath, anxiety, nausea, vomiting, diarrhea, constipation, and agitation.

Additional information regarding these data items and time points can be found in the draft [HOPE Guidance Manual](https://www.cms.gov/files/document/draft-hope-guidance-manualv100.pdf) of the [CMS HOPE webpage](https://www.cms.gov/medicare/quality/hospice/hope) and the PRA package that accompanies this proposed rule which can be accessed on the [CMS PRA Listing webpage](https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing) (not available at the time of this writing).

CMS proposes that only in-person visits would count for the collection of data for these proposed measures – that is, telehealth calls would not count for a reassessment. CMS further proposes that a follow-up visit cannot be the same visit as the initial assessment, but it can occur later in the same day (as a separate visit). **CMS seeks comment on whether only in-person visits are appropriate for collection of data for these proposed measures or if other types of visits, such as telehealth, should be included.**

For both the proposed Timely Reassessment of Pain Impact and proposed Timely Reassessment of Non-Pain Symptom Impact measures, beneficiaries would be included in the denominator if they have a moderate or severe level of pain or non-pain symptom impact, respectively, at their initial assessment. However, certain exclusions would apply to these denominators, such as beneficiaries who die or are discharged alive before the two-day window, if the patient/caregiver refused the reassessment visit, the hospice was unable to contact the patient/caregiver to perform the reassessment, the patient traveled outside the service area, or the patient was in the ER/hospital during the two-day follow-up window. In these situations, CMS proposes that a hospice would be unable to conduct a reassessment due to circumstances beyond their control, and therefore these situations would not be included in the measure denominator. The proposed numerators for these measures will reflect beneficiaries who did receive a timely symptom re-assessment. These will include beneficiaries who receive a separate HOPE reassessment within two calendar days of the initial assessment (for example, if a pain has moderate or severe symptoms assessed on Sunday, the hospice would be expected to complete the reassessment on or before Tuesday).

Testing of the two proposed process quality measures has thus far relied on data from the HOPE beta (field) test. Therefore, CMS proposes future measure testing to be conducted using a full sample of hospices collected after HOPE has been implemented nationally, to support further development of quality measures.

*Update on Future Quality Measure (QM) Development*

CMS continues to consider developing hybrid quality measures that could be calculated from multiple data sources, such as claims, HOPE data, or other data sources (for example, CAHPS Hospice Survey).  A Technical Expert Panel (TEP) was convened in 2022 and 2023 for new measure development. The TEP agreed that CMS should consider applying several risk adjustment factors, such as age and diagnosis, to ensure comparable, representative comparisons between hospices. The TEP also suggested using length of hospice stay but not functional status as risk adjustment factor for hospice performance.

To support new HOPE-based measure development, a TEP was also convened and held several meetings between 2020 and 2023. The TEP recommended specifications for the two HOPE-based quality measures proposed in this Rule – Timely Reassessment of Pain Impact and Timely Reassessment of Non-Pain Symptom Impact. CMS also sought the TEP’s input on several measurement concepts proposed for future quality measure development. Of these measurement concepts, the TEP supported CMS further developing the *Education for Medication Management* and *Wound Management Addressed in Plan of Care*process concepts. More information about the TEP recommendations can be found in the [2023 HQRP TEP Report](https://www.cms.gov/files/document/2023-hqrp-tep-summary-report.pdf). CMS will take the TEP’s recommendations under consideration as it continues to develop HOPE-based quality measures.

Additional information about CMS’s HOPE-based measure development efforts is available in the [2022-2023 HQRP TEP Summary Report](https://www.cms.gov/files/document/2023-hqrp-tep-summary-report.pdf) and the [2023 Information Gathering Report](https://www.cms.gov/files/document/hospicequalityreportingprograminformationgatheringreport2023508.pdf).

*Proposal to Implement the Hospice Outcomes & Patient Evaluation (HOPE) Assessment Instrument*

**CMS proposes to begin collecting the HOPE standardized patient level data collection tool on or after October 1, 2025 to support the proposed quality measures anticipated for public reporting on or after CY 2027**. After this date hospices would not be required to collect or submit the Hospice Item Set (HIS).

HOPE v1.0 would contain demographic, record processing, and patient-level standardized data elements that would be collected by all Medicare certified hospices for all patients over the age of 18, regardless of payer source, to support HQRP quality measures. CMS states elsewhere in the proposed rule that it would require hospices to complete and submit a standardized set of items for each patient to capture patient-level data, regardless of payer or patient age. This may be data that is separate from the HOPE for patients under the age of 18 and clarification from CMS is needed for this.

The newly standardized set of items would have to be completed at admission and discharge, and at two Hospice Update Visit (HUV) timepoints within the first 30 days after the hospice election. CMS would impose a 4 percent reduction on hospices for failure to submit HOPE collections timely.

CMS reiterated that the HOPE would provide data for the HQRP quality measures and its requirements through standardized data collection; and provide additional clinical data that could inform future payment refinements.  HOPE would also contribute to the patient’s plan of care through providing patient data throughout the hospice stay.

The draft [HOPE](https://www.cms.gov/files/document/drafthopev100allitemmockup.pdf) tool is available now for review. In past rules, CMS has described this as a new collection tool, however CMS states in this rule that it believes it is better characterized as a modification of, and functional replacement for, the existing HIS structure.

Also in the past CMS has stated 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 could appropriately and feasibly apply to hospice y. Many patients move through other providers within the healthcare system to hospice. Therefore, **CMS is considering tracking key demographic and social risk factor items that apply to hospice** because they could support goals for continuity of care, overall patient care and well-being, development of infrastructure for the interoperability of electronic health information, and health equity. CMS will propose any additions of standardized elements in future rulemaking.

Data elements that would be collected from HOPE would be in real-time and based on the hospice’s interactions with the patient and family/caregiver. They would provide additional information to contribute to the patient’s care plan throughout the hospice stay (not just at admission and discharge). These data elements represent domains such as Administrative, Preferences for Customary Routine Activities, Active Diagnoses, Health Conditions, Medications, and Skin Conditions. HOPE data would be collected by hospice staff for each patient admission at three distinct time points:

* admission,
* the hospice update visit (HUV), and
* discharge.

Not all HOPE items would be required to be completed at every timepoint and the proposed time points could be revised in future rulemaking. More information can be found in the draft [HOPE Guidance Manual](https://www.cms.gov/files/document/draft-hope-guidance-manualv100.pdf) (final Manual to be available after publication of the final rule).

CMS intends to make HOPE data publicly available, as expected.  However, CMS will first need to establish the scientific soundness of the quality measures and establish the reliability and validity of the measures prior to public reporting. At least four quarters of data will need to be analyzed for this. Typically, the first two quarters of data reflect the learning curve of the providers as they adopt a standardized data collection; these data are not used to establish reliability and validity. Therefore, the data from the first quarter of the HOPE (anticipated to be Q4 CY2025, if HOPE data collection begins in October 2025) will not be used for assessing validity and reliability of the quality measures. The data collected by hospices during the four quarters of CY2026 would be analyzed in CY2027.  CMS would decide after analysis of the data if some or all the quality measures based on the data would be publicly reported.

Additionally, CMS proposes that public reporting of the proposed quality measures would be implemented no earlier than FY 2027. Alternatively, CMS proposes public reporting may occur during the FY 2028 APU year, allowing ample time for data analysis, review of measures’ appropriateness for use for public reporting, and allowing hospices the required time to review their own data prior to public reporting. CMS will propose the timeline for public reporting of data in future rulemaking and welcomes comment on what should be considered when developing future proposals related to public reporting.

Hospice providers will need to use vendor software to submit HOPE records to CMS. As with HIS, facilities that fail to submit all required HOPE assessments to CMS for at least 90% of their patients will be subject to a 4% reduction. CMS plans to conduct trainings and provide more information on the HOPE v1.0 in the coming months.

CMS stated it would provide the HOPE technical date specifications for software developers and vendors on the CMS web site and expects software developers and vendors to begin development of their own products and not wait for final specifications. Rather, software developers and vendors are encouraged to thoroughly review the draft technical data specifications and provide feedback to CMS so it may address potential issues adequately and in a timely manner. CMS indicated that it will conduct a call with software developers and vendors after the draft specifications are posted.

*Proposed CAHPS Hospice Survey Changes*

In the Fiscal Year 2024 Hospice Payment Rate Update Final Rule (88 FR 51164), CMS provided the results of a mode experiment conducted with 56 large hospices in 2021. The experiment tested a web-mail mode, modification to survey administration protocols such as adding a prenotification letter and extending the data collection period, and a revised survey version. Because we believe the results of the experiment were successful, we are proposing changes to the CAHPS Hospice Survey and administrative protocol. The revised survey is shorter and simpler than the current survey and includes new questions on topics suggested by stakeholders. Specifically, proposed changes to the survey and the quality measures derived from testing include:

* Removal of three nursing home items and an item about moving the family member that are not included in scored measures.
* 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 two new items, which will be used to calculate a new Care Preferences measure.
* Simplified wording to component items in the Hospice Team Communication, Getting Timely Care, and Treating Family Member with Respect measures.

**CMS is proposing to implement the revised CAHPS Hospice Survey beginning with January 2025 decedents and seeks comments on the proposed changes before finalization.**

Relative to the implementation of the revised Survey is public reporting. CMS considers all but one of the proposed changes substantive and for these measures CMS anticipates that the first Care Compare refresh in which publicly reported measures scores would be updated to include the new measures would be November 2027, with scores calculated using data from Q1 2025 through Q4 2026. Because measure scores are calculated quarterly, and Star Ratings are calculated every other quarter, these changes may be introduced in different quarters for measure scores and Star Ratings. In the interim period, measure scores would be made available to hospices confidentially in their Provider Preview reports once they met a threshold number of completed surveys. For the non-substantive change, Hospice Team Communication, CMS would continue to publicly report it and use it for the Star Ratings in the transition period between the current and new surveys.

During the transition period, scores and Star Ratings would be calculated by combining scores from quarters using the current and new survey. As a result of the survey measure changes, CMS proposes that the Family Caregiver Survey Rating summary Star Rating would be based on seven measures rather than the current eight measures during the interim period until a full eight quarters of data are available for the “Getting Hospice Care Training” measure. The summary Star Rating would be based on nine measures once eight quarters of data are available for the new Care Preference and Getting Hospice Care Training measures.

**CMS also proposes to add a web-mail mode (email invitation to a web survey, with mail follow-up to non-responders); to add a pre-notification letter; and to extend the field period from 42 to 49 days, beginning with January 2025 decedents.**The web-mail mode would be an alternative to the current modes (mail-only, telephone-only, and mixed mode (mail with telephone follow-up)) that hospices could select. The 2021 mode experiment found increases in response rates with these changes to survey administrative protocols.

**With the introduction of a new mode of survey administration and survey items, CMS proposes updating the analytic adjustments that adjust responses for the effect of mode on survey responses.**

*Below is a table outlining the changes to the CAHPS Hospice Survey*and then insert the table.

**TABLE 14: Comparison of Current and Proposed CAHPS Hospice Survey Measures**

|  |  |  |
| --- | --- | --- |
| **MEASURE** | **Item(s) in Current Measure** | **Item(s) in Proposed Revised or New Measure** |
| Getting Timely Care | “How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?” | “How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?” |
|  | “While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?” | “When you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?” |
| Hospice Team Communication | “While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family member?” | “How often did the hospice team let you know when they would arrive to care for your family member?” |
|  | “While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?” | “How often did the hospice team explain things in a way that was easy to understand?” |
|  | “While your family member was in hospice care, how often did the hospice team keep you informed about your family member’s condition? | “How often did the hospice team keep you informed about your family member’s condition?” |
|  | “While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member’s condition or care?” | N/A (removed from revised survey) |
|  | “How often did the hospice team listen carefully to you when you talked with them about problems with your family member’s hospice care?” | “How often did the hospice team listen carefully to you when you talked with them about problems with your family member’s hospice care?” |

**TABLE 14: Comparison of Current and Proposed CAHPS Hospice Survey Measures**

|  |  |  |
| --- | --- | --- |
| Treating Family Member with Respect | “While your family member was in hospice care, how often did the hospice team listen carefully to you?” | “While your family member was in hospice care, how often did the hospice team listen carefully to you?” |
|  | “While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?” | “How often did the hospice team treat your family member with dignity and respect?” |
|  | “While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member?” | “How often did you feel that the hospice team really cared about your family member?” |
| Getting Help for Symptoms | “Did your family member get as much help with pain as he or she needed?” | “Did your family member get as much help with pain as they needed?” |
|  | “How often did your family member get the help he or she needed for trouble breathing?” | “How often did your family member get the help they needed for trouble breathing?” |
|  | “How often did your family member get the help he or she needed for trouble with constipation?” | “How often did your family member get the help they needed for trouble with constipation?” |
|  | “How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness?” | “How often did your family member get the help they needed from the hospice team for feelings of anxiety or sadness?” |
| Getting Emotional and Religious Support | “Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs. While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?” | “Support for religious, spiritual, or cultural beliefs may include talking, praying, quiet time, and respecting traditions. While your family member was in hospice care, how much support for your religious, spiritual, and cultural beliefs did you get from the hospice team?” |
|  | “While your family member was in hospice care, how much emotional support did you get from the hospice team?” | “While your family member was in hospice care, how much emotional support did you get from the hospice team?” |
|  | “In the weeks after your family member died, how much emotional support did you get from the hospice team.” | “In the weeks after your family member died, how much emotional support did you get from the hospice team.” |
| Getting Hospice Care Training | “Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with you or your family member?” | N/A (removed from revised survey) |
|  | “Did the hospice team give you the training you needed about what side effects to watch for from pain medicine?” | N/A (removed from revised survey) |
|  | “Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member?” | N/A (removed from revised survey) |
|  | “Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing?” | N/A (removed from revised survey) |
|  | “Did the hospice team give you the training you needed about what to do if your family member became restless or agitated?” | N/A (removed from revised survey) |
|  | N/A (not on current survey) | “Hospice teams may teach you how to care for family members who need pain medicine, have trouble breathing, are restless or agitated, or have other care needs. Did the hospice team teach you how to care for your family member?” |
|  | N/A (not on current survey) | “Did the hospice team make an effort to listen to the things that mattered most to you or your family member?” |
|  | N/A (not on current survey) | “Did the hospice team provide care that respected your family member’s wishes?” |
|  | “Please answer the following questions about your family member’s care from the hospice named on the survey cover. Do not include care from other hospices in your answers. Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member’s hospice care?” | “Please answer the following questions about the hospice named on the survey cover. Do not include care from other hospices in your answers. Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member’s hospice care?” |
| Willingness to recommend | “Would you recommend this hospice to your friends and family?” | “Would you recommend this hospice to your friends and family?” |

*Request for Information (RFI) Regarding Future HQRP Social Determinants of Health (SDOH) Items*

SDOH are the socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health. SDOH can be grouped into five broad domains:

* economic stability;
* education access and quality;
* health care access and quality;
* neighborhood and built environment; and
* social and community context.

Health-related social needs (HRSNs) are the resulting effects of SDOH, which are individual-level, adverse social conditions that negatively impact a person’s health or health care. Examples of HRSN include lack of access to food, housing, or transportation, and have been associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs. Certain HRSNs can lead to unmet social needs that directly influence an individual’s physical, psychosocial, and functional status.

CMS reiterated its commitment to developing approaches to meaningfully incorporate the advancement of health equity into the HQRP and reminded readers that it has repeatedly heard from the public that CMS should develop new HQRP mechanisms to better address significant and persistent health care outcome inequities. Analysis of SDOH measures could allow providers to more effectively identify patient needs and identify opportunities for effective partnership with community-based organizations with the capacity to help address those needs.

**CMS is working toward collecting SDOH data elements in hospice in support of quality measurement and seeks public comment on these efforts.** CMS reviewed SDOH domains to determine which domains align across post-acute care (PAC) and hospice care settings, circumstances, and setting-specific care goals. CMS identified four SDOH domains that are relevant across the PAC and hospice care setting:

* housing instability,
* food insecurity,
* utility challenges, and
* barriers to transportation access.

These data elements have supported measures of quality in other settings. CMS outlined potential data collection items for each of these domains and is requesting input on which of the data collection items are suitable for the hospice setting, and how they may need to be adapted to be more appropriate for the hospice setting.

NAHC staff continue to analyze the proposals in the rule and will provide additional details in the coming days. We will also schedule a webinar in the near future to review the details of this proposed rule and will also be seeking feedback to inform the submission of comments to CMS.