Public Policy

HCA Public Policy No. 1-2021

TO: HCA HOSPICE PROVIDER MEMBERS

FROM: PATRICK CONOLE, VICE PRESIDENT, FINANCE & MANAGEMENT

RE: CMS ISSUES PROPOSED FY 2022 HOSPICE PAYMENT RULE

DATE: APRIL 14, 2021

The U.S. Centers for Medicare and Medicaid Services (CMS) has released its hospice proposed rule (CMS–1754-P) to update the fiscal year (FY) 2022 (October 1, 2021 through September 30, 2022) Medicare payment rates and the wage index for hospices serving Medicare beneficiaries.

The proposed rule is currently at https://www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf.

CMS estimates a 2.3 percent ($530 million) increase in national hospice payments for FY 2022 over FY 2021.

In addition to the payment updates, the rule contains numerous proposed changes, a data and utilization analysis, and a request for feedback on a number of issues, including:

- A proposed FY 2022 aggregate cap amount of **$31,389.66**.
- Summary of CMS hospice utilization data, spending outside of hospice, determinations of relatedness/unrelatedness, visits in the last week of life, and other feedback on many of these trends.
- Revision and rebasing of the labor shares of the hospice payment rates.
- An updated FY 2022 Hospice Wage Index at: https://www.cms.gov/medicaremedicare-fee-service-paymenthospicehospice-regulations-and-notices/cms-1754-p.
- Clarifications to the regulations governing the election statement addendum requirement that was implemented on October 1, 2020.

- Making permanent select regulatory blanket waivers that were issued during the COVID-19 Public Health Emergency (PHE).

- Multiple proposals and changes to the Hospice Quality Reporting Program (HQRP).

The following are key highlights of the rule.

Proposed Hospice Cap Amount for FY 2022

The hospice payment system includes a statutory per-patient aggregate cap. The cap limits the overall payments made per-patient to a hospice annually. As mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), the cap amount for accounting years that end after September 30, 2016 and before October 1, 2025 must be updated by the hospice payment update percentage, rather than the Consumer Price Index (CPI). Therefore, the proposed cap amount for FY 2022 will be **$31,389.66** (This is the FY 2021 cap amount of $30,683.93 increased by 2.3 percent.)

Hospice Utilization, Spending Patterns and Feedback Requested

In the rule, CMS provides detailed analysis of hospice spending and utilization patterns. However, CMS is continuing to analyze the effects of the COVID-19 PHE, so its data analysis is limited to the most complete data available from FY 2019.

While numerous items were covered as part of this section, there are particular items of note, including that hospice average length of election, median lifetime length of stay, and average lifetime length of stay have all increased between FY 2018 and FY 2019. Average live discharge rates remain stable at approximately 17% per year, with 37.5% of live discharges being attributable to revocations and 37.2% due to the beneficiary being determined as no longer eligible for hospice care.

Service Intensity Add-on payments applicable to the final week of life have increased from $88 million in FY 2016 to $150 million in FY 2019, although the total amount of minutes of care provided by skilled nurses and social workers in the last seven days of life have changed only modestly from FY 2015 to FY 2019. Medicare paid over $1 billion for non-hospice spending under Parts A, B, and D during hospice elections in FY 2019, representing an increase in non-hospice spending under Parts A and B of 18.7% between FY 2016 and FY 2019. Non-hospice spending for Part D drugs increased from $353 million in FY 2016 to $499 million in FY 2019. CMS states in the rule that there has been a notable increase of spending for Part D drugs that CMS classifies as "maintenance" drugs.

CMS is seeking comments on all aspects of its utilization analysis provided in the proposed rule, including:

- How changes in patient characteristics may have influenced any changes in the provision of hospice services.

- Skilled visits in the last week of life and particularly what factors determine how and when visits are made as an individual approaches the end of life.

- Information surrounding determinations made by hospices as to what items, services, and drugs are "related" versus "unrelated" to the terminal illness and related conditions, and on what other factors may influence whether/how certain services are furnished under hospice.

- Whether the hospice election statement addendum has changed the way hospices make care decisions and how the addendum is used to prompt discussions with beneficiaries and non-hospice providers to ensure beneficiary care needs are met.

FY 2022 Proposed Labor Shares

Previously, CMS has indicated an interest in potential changes to the labor and non-labor shares of the hospice payment rates, particularly given the collection of expanded data as part of the revised hospice cost report. As part of the FY 2022 rule, CMS is proposing to rebase and revise the labor shares for Continuous Home Care (CHC), Routine Home Care (RHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP) using 2018 Cost Report data from free-standing hospices. CMS elected not to use provider-based hospice cost reports since few of these hospice providers passed the Level I edits and CMS did not believe these reports were reliable enough to be included.

As part of its proposed methodology, CMS is proposing to derive a compensation cost weight for each level of care based on five major components:

1. Direct patient care salaries and contract labor costs – costs associated with medical services provided by medical personnel including physicians, RNs, and hospice aides.

2. Direct patient care benefits costs.

3. Other patient care salaries – salaries attributable to patient transportation, labs, imaging services, and other services.

4. Overhead salaries.

5. Overhead benefits costs.

Total compensation costs for each provider would be calculated by summing the costs of the five components listed above for each level of care.

In order to develop the compensation cost weights, CMS identified a sample of providers that met the Level I Cost Report edits, then further trimmed the sample to meet certain data standards depending on the level of care. Then, to derive the proposed compensation cost weights for each level of care for each provider, CMS divided the compensation costs for each level of care by total costs for each level

of care and once again trimmed the data for each level of care to remove outliers. CMS arrived at the following proposed labor shares by level of care, as compared with current labor shares.

Table 1: FY 2022 Proposed Labor Shares		
Service	**Proposed Labor Share**	**Current Labor Share**
Continuous Home Care	74.60%	68.71%
Routine Home Care	64.70%	68.71%
Inpatient Respite Care	60.10%	54.13%
General Inpatient Care	62.80%	64.01%

Proposed FY 2022 Hospice Wage Index

As part of the FY 2021 Hospice Wage Index final rule, CMS incorporated changes from a September 2018 OMB bulletin that established revisions to the delineations of Metropolitan Statistical Areas (MSAs), Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineations in these areas.

To mitigate the impact of these changes, CMS applied a 5 percent cap in FY 2021 on any decrease in a geographic area's wage index value from the wage index value from the previous year. There are no such changes anticipated or proposed for FY 2022, although hospice providers must take note that the 5 percent cap on any reduction in the wage index value (applied for FY 2021) will be lifted for FY 2022, and the full impact of the FY 2022 changes will be felt. CMS has indicated that, as part of its FY 2022 Inpatient Prospective Payment System (IPPS) rule, CMS is proposing to rebase and revise the IPPS market baskets (upon which the hospice wage index is based) to reflect a 2018 base year. CMS will provide additional information when the IPPS or hospital proposed rule is published.

For FY 2022, the proposed hospice wage index would be based on the FY 2022 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2017 and before October 1, 2018 (FY 2018 cost report data). The appropriate wage index value is applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. 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.

As proposed, there continues to be 15 Core-Based Statistical Areas (CBSAs) wage index designations in New York. HCA has created **Appendix A** at the end of this memorandum that summarizes all the proposed changes for New York hospices in FY 2022. The following are highlights of these changes:

- Nine CBSAs are proposed to see increases in their 2022 wage index. They include: Buffalo-Cheektowaga New York; Elmira; Ithaca; Kingston; New York City and White Plains; Poughkeepsie and Newburgh; Rochester; Syracuse; and Watertown-Fort Drum.

- Five CBSAs are proposed to see decreases in their 2022 wage index. They include: New York Rural Areas; Albany-Schenectady-Troy; Binghamton; Nassau and Suffolk; and Utica-Rome.

- CMS is proposing no wage index change in the Glen Falls CBSA.

HCA is pleased that the Ithaca (a 14.01% increase), Elmira (a 5.61% increase), NYC-White Plains (a 2.77% increase), Watertown-Fort Drum (a 5.85% increase) and Syracuse (a 3.48% increase) CBSAs are proposed to see significant wage index increases for FY 2022 but is concerned that New York Rural Areas will see a proposed -1.42% decrease and Nassau-Suffolk a -2.05% decrease.

CMS's proposed wage index tables are at https://www.cms.gov/medicaremedicare-fee-service-paymenthospicehospice-regulations-and-notices/cms-1754-p.

The wage index value is applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving routine home care (RHC) or continuous home care (CHC). The wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving general inpatient care (GIP) or inpatient respite care (IRC). Table 1 on page 4 of this memorandum provides CMS's proposed labor percentages for the proposed FY 2022 payment rates.

Proposed FY 2022 Market Basket Update

The proposed hospice payment update percentage for FY 2022 is based on the current estimate of the inpatient hospital market basket update of 2.5 percent (based on IHS Global Inc.'s fourth-quarter 2020 forecast with historical data through the third quarter of 2020). Due to requirements in the Affordable Care Act (ACA), the inpatient hospital market basket update for FY 2022 of 2.5 percent must be reduced by a mandated productivity adjustment (currently estimated to be 0.2 percentage points for FY 2022). In effect, the proposed hospice payment or market basket update percentage for FY 2022 would be **2.3 percent**.

CMS states that it is proposing to rebase and revise the IPPS market basket to reflect a 2018 base year which could impact the hospice market basket when the FY 2022 final rule is issued in August.

Proposed FY 2022 Hospice Payment Rates

While there are four payment levels for hospice care, CMS, starting in January 2016, imposed a bifurcated system of payment for the Routine Home Care (RHC) level of care: 1) one rate for days 1 through 60 of care; and 2) a lower rate for days 61 and thereafter. Base payments are adjusted by the wage index to account for geographic differences.

To update the proposed FY 2022 hospice payment rates, CMS is making the following adjustments:

- The application of a service intensity add-on budget neutrality factor is used only for the RHC rates, to make sure service intensity add-on rates are budget neutral.
- Aa wage index standardization factor.
- A labor share standardization factor.
- A 2.3 percent hospice payment update, which is based on the estimated inpatient hospital market-basket update of 2.5 percent, reduced by a productivity adjustment (estimated to be 0.2 percentage points for FY 2022).

Table 2 shows CMS's proposed FY 2022 RHC payment rates and Table 3 shows CMS's proposed FY 2022 Continuous Home Care (CHR), Inpatient Respite Care (IRC) and General Inpatient Care (GIP) payment rates.

Table 2: Proposed FY 2022 Hospice RHC Payment Rates

Code	Description	FY 2021 Final Payment Rates	Service Intensity Add-On Budget Neutrality Factor	Wage Index Standardization Factor	Labor Share Standardized Factor	Proposed FY 2022 Hospice Payment Update	Proposed FY 2022 Hospice Payment Rates
651	Routine Home Care (Days 1-60)	$199.25	1.0004	1.0002	0.9993	X 1.023	$203.81
651	Routine Home Care (Days 61+)	$157.49	1.0005	1.0001	0.9988	X 1.023	$161.02

Table 3: Proposed FY 2022 Hospice CHC, IRC and GIP Payment Rates

Code	Description	FY 2021 Final Payment Rates	Wage Index Standardization Factor	Labor Share Factor	Proposed FY 2022 Hospice Payment Update	Proposed FY 2022 Hospice Payment Rates
652	CHC (Full Rate = 24 hours of care at $59.68 per hour)	$1,432.41 ($59.68 per hour)	0.9998	1.0005	X 1.023	$1465.79 ($61.067 per hour)
655	IRC	$461.09	1.0007	1.0051	X 1.023	$474.43
656	GIP	$1,045.66	1.0013	0.9993	X 1.023	$1,070.35

Notes:

1. For Hospice Payment Rates in Table 2 and 3, CMS will 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 fiscal year.

2. All of the above values are **not** adjusted for the wage index.

Proposed Clarifying Regulation Text Changes for the Hospice Election Statement Addendum

In the FY 2020 hospice rule, CMS finalized modifications to the hospice election statement and included a new condition for payment requiring a hospice, upon request, to provide the beneficiary (or representative) an election statement addendum outlining the items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. A signed addendum means that the hospice discussed the addendum and its contents with the beneficiary (or representative). Additionally, in the event that a beneficiary (or representative) does not request the addendum, CMS expects hospices to document, in some fashion, that an addendum has been discussed with the patient (or representative) at the time of election, similar to how other patient and family discussions are documented in the hospice's clinical record.

In this FY 2022 proposed rule CMS states that it is necessary for the hospice to document that the addendum was discussed and whether or not it was requested, in order to prevent potential claims denials related to any absence of an addendum (or addendum updates) in the medical record.

CMS also addresses some of the outstanding questions and issues about the election statement addendum that the hospice industry has brought to its attention. Specifically, various stakeholders shared with CMS that the addendum is sometimes not requested at the time of election but is requested within the five days after the effective date of election. In these situations, the request is considered to be made during the course of care, requiring the hospice to provide the addendum within three days. This may actually require the hospice to provide the addendum before the five-day comprehensive assessment period ends. This places an unnecessary burden on the hospice and the beneficiary to complete the assessment prior to when it would otherwise be completed.

Industry representatives, including our colleagues at the National Association for Home Care and Hospice (NAHC), recommended that CMS consider revising its guidance for situations where the addendum is not requested at the time of election but is requested within the five days after the effective date of election. CMS is proposing to allow the hospice to furnish the addendum within five days from the date of a beneficiary or representative request, if the request is within five days from the date of a hospice election. For example, if the patient elects hospice on December 1 and requests the addendum on December 3, the hospice would have until December 8 to furnish the addendum.

The election statement and addendum regulations require that the beneficiary/legal representative sign the addendum and any updates to the addendum. There is not a specific timeframe for signature in the regulation, but CMS stated in the FY 2021 final rule that it expects that beneficiaries or their representative would sign the addendum at the time it is provided. Since implementation of the addendum in October 2020, stakeholders have shared with CMS examples of situations in which the date that the hospice furnished the addendum to the beneficiary (or representative) may differ from the date that the beneficiary or representative signs the addendum (i.e. the addendum has to be mailed/e-mailed, beneficiary/representative requests time to review the addendum, representative

requests the addendum be left at the beneficiary's residence but the representative does not retrieve the addendum for some time, etc.). CMS proposes to clarify in regulation that the "date furnished" must be within the required timeframe (that is, three or five days of the beneficiary or representative request, depending on when such request was made), rather than the signature date being required in that timeframe. At Section 418.24(c)(10), CMS proposes that the hospice would include the "date furnished" in the patient's medical record and on the addendum itself.

In situations where the beneficiary or representative refuses to sign the addendum, CMS clarified that the hospice must document clearly in the medical record (and on the addendum itself) the reason the addendum is not signed in order to mitigate a claims denial for this condition for payment. In such a case, although the beneficiary has refused to sign the addendum, the "date furnished" must still be within the required timeframe (that is, within three or five days of the beneficiary or representative request, depending on when such request was made), and noted in the chart and on the addendum itself. CMS also proposes to clarify in regulation that if only a non-hospice provider or Medicare contractor requests the addendum (and not the beneficiary or representative), the non-hospice provider is not required to sign the addendum.

Other proposals related to the addendum include:

- For instances in which the beneficiary or representative requests the addendum at the time of election but dies prior to signing the addendum, CMS proposes conforming regulation changes at Section 418.24(c) to reflect the current policy that the hospice would not be required to furnish the addendum as the requirement would be deemed as being met.

- If the patient revokes or is discharged within the required timeframe (three or five days after a request, depending upon when such request was made), but the hospice has not yet furnished the addendum, the hospice is not required to furnish the addendum [Section 418.24(d)(4)].

- In the event that a beneficiary requests the addendum and the hospice furnishes the addendum within three or five days (depending upon when the request for the addendum was made), but the beneficiary dies, revokes, or is discharged prior to signing the addendum, a signature from the individual (or representative) is no longer required [Section 418.24(d)(5)]. CMS would continue to expect that the hospice would note the date furnished in the patient's medical record and on the addendum, if the hospice has already completed the addendum, as well as an explanation in the patient's medical record noting that the patient died, revoked, or was discharged prior to signing the addendum.

- CMS proposes conforming regulation changes at Section 418.24(c) in alignment with sub-regulatory guidance indicating that hospices have "3 days," rather than "72 hours" to meet the requirement to furnish the addendum when a patient requests the addendum during the course of hospice care. This means that hospice providers must furnish the addendum to the beneficiary or representative on or before the third day after the date of the request.

CMS is soliciting comments on all of these proposed clarifications and regulatory changes to the hospice addendum.

Hospice CoP Waivers Made Permanent

The current hospice aide competency standard regulations at Section 418.76(c)(1) require the aide to be evaluated by observing an aide's performance of the task with a patient. CMS proposes to make similar changes to hospice aide competency standards to those already made with respect to home health aides [see Section 484.80(c)] in the hospice regulations at Section 418.76(c)(1), which describes the process for conducting hospice aide competency evaluations and proposes to define both "pseudo-patient" and "simulation" at Section 418.3. Specifically, CMS is proposing to permit skill competencies to be assessed by observing an aide performing the skill with either a patient or a pseudo-patient as part of a simulation. The proposed definitions are as follows:

- "Pseudo-patient" means a person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the hospice aide trainee and must demonstrate the general characteristics of the primary patient population served by the hospice in key areas such as age, frailty, functional status, cognitive status and care goals.

- "Simulation" means a training and assessment technique that mimics the reality of the home care environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision-making and critical thinking.

These proposed changes would allow hospices to utilize pseudo-patients, such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient.

Relative to hospice aide training and evaluation, CMS is proposing to amend the requirement at Section 418.76(h)(1)(iii) to specify that if an area of concern is verified by the hospice during the RN on-site supervisory visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skill(s) in accordance with Section 418.76(c). This proposed change would permit the hospice to focus on the hospice aides' specific deficient and related skill(s) instead of completing another full competency evaluation.

These are changes HCA and NAHC have long advocated for and are pleased to see CMS propose. The changes align with the home health aide competency, training and evaluation requirements making operations more efficient for those providers utilizing aides in both hospice and home health.

Proposals and Updates to the Hospice Quality Reporting Program

The Hospice Quality Reporting Program (HQRP) specifies reporting requirements for both the Hospice Item Set (HIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. CMS is required by statute to change the payment reduction, from 2 to 4 percentage points, for failing to meet hospice quality reporting requirements. Beginning FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points. Beginning with the FY 2024 APU, and for each subsequent year, it will be reduced by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

In addition, section 407(a)(2) of the Consolidated Appropriations Act (CAA) of 2021 removes the prohibition on public disclosure of hospice surveys performed by a national accreditation agency, thus allowing CMS to disclose such accreditation surveys. Section 407(a)(1) of the CAA of 2021 also adds new requirements to require each state and local survey agency, and each national accreditation body with an approved hospice accreditation program, to submit information on any survey or certification made with respect to a hospice program. Such information shall include any inspection report made by such survey agency or body with respect to such survey or certification, any enforcement actions taken as a result of such survey or certification, and any other information determined appropriate by CMS. This information will be published publicly on CMS's website, such as Care Compare, in a manner that is easily accessible, readily understandable, and searchable no later than **October 1, 2022**.

CMS also made multiple other proposals related to the HQRP. An overview of the main areas are addressed is below.

Revisions to the Hospice Item Set (HIS)

CMS is proposing to remove the following seven National Quality Forum (NQF) "Hospice Item Set process measures" from HQRP beginning in FY 2022:

- NQF no. 1617 Patients Treated with an Opioid who are Given a Bowel Regimen
- NQF no. 1634 Pain Screening
- NQF no. 1637 Pain Assessment
- NQF no. 1638 Dyspnea Treatment
- NQF no. 1639 Dyspnea Screening
- NQF no. 1641 Treatment Preferences
- NQF no. 1647 Beliefs/Values Addressed (if desired by the patient)

On April 1, 2017, CMS implemented NQF no. 3235 – Comprehensive Assessment at Admission. In the FY 2022 proposed rule, CMS provides details on why it believes the "composite measure" is a better measure than the seven individual measures.

Proposal to add a "Claims-Based Index Measure" – the Hospice Care Index

CMS proposes a new hospice quality measure – the "Hospice Care Index" (HCI). HCI is a single measure comprised of the following ten indicators calculated from Medicare claims data that simultaneously monitors each of the ten indicators.

- Continuous Home Care (CHC) or General Inpatient (GIP) Provided – identifies hospices that provided at least one day of hospice care under the CHC or the GIP levels of care during the period examined.

- Gaps in Nursing Visits – identifies whether a hospice is below the 90th percentile in terms of how often hospice stays of at least 30 days contain at least one gap of eight or more days without a nursing visit.

- Early Live Discharges – identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that occur within 7 days of hospice admission during the fiscal year examined.

- Late Live Discharges – identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that occur on or after the 180th day of hospice.

- Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission (Burdensome Transitions Type I) – identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that are followed by a hospitalization (within two days of hospice discharge) and then followed by a hospice readmission (within two days of hospitalization) during the FY examined.

- Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital (Burdensome Transitions Type II) – identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that are followed by a hospitalization (within two days of hospice discharge) and then the patient dies in the hospital.

- Per-beneficiary Medicare Spending – identifies whether a hospice is below the 90th percentile in terms of the average Medicare hospice payments per beneficiary.

- Nurse Care Minutes Per Routine Home Care (RHC) Day – identifies whether a hospice is above the 10th percentile in terms of the average number of nursing minutes provided on RHC days during the reporting period examined.

- Skilled Nursing Minutes on Weekends – identifies whether a hospice is at or above the 10th percentile in terms of the percentage of skilled nursing minutes performed on weekends compared to all days during the reporting period examined.

- Visits Near Death – identifies whether a hospice is at or above the 10th percentile in terms of the percentage of beneficiaries with a nurse and/or medical social services visit in the last three days of life.

The rule makes other clarifications and proposals regarding the HQRP including:

- **Update on the Hospice Visits in the Last Days of Life (HVLDL) and Hospice Item Set (HIS) Version 3.00**. CMS announced at the end of 2020 that it was replacing the Hospice Visits When Death is Imminent (HVWDII) measure with a re-specified version of the measure: Hospice Visits in Last Days of Life (HVLDL). The data source for the HVLDL measure is hospice claims, which eliminates the need for hospice visit data to be gathered from the HIS. Therefore, CMS revised the HIS-Discharge by removing Section O. These changes were approved by the Office of Management and Budget (OMB) on February 16, 2021. The HIS Manual Version 3.00 became effective on February 16, 2021 and expires on February 29, 2024.

- **Proposal to revise Section 418.312(b) on submission of HQRP data**. This proposed change would revise regulations to include administrative data as part of the HQRP, and correct technical errors identified in the FY 2016 and 2019 Hospice final rules.

- **Update regarding the Hospice Outcomes & Patient Evaluation (HOPE) development**. The draft HOPE has undergone cognitive and pilot testing, and will undergo field testing to establish reliability, validity and feasibility of the assessment instrument. CMS anticipates proposing the HOPE in future rulemaking after testing is complete.

- **Update on quality measure development for Future Years**. CMS is soliciting public comment on the HOPE and claims-based quality measures, which are outlined in the proposed rule, to distinguish between high and low quality hospices, support health care providers in quality improvement efforts, and provide support to hospice consumers in helping to select a hospice provider. CMS is also considering developing hybrid quality measures that would be calculated using claims, assessment (HOPE), or other data sources. Hybrid quality measures allow for a more comprehensive set of information about care processes and outcomes than can be calculated using claims data alone. CMS is also seeking public comment on hybrid quality measures.

- **CAHPS hospice survey participation requirements for the FY 2023 APU and subsequent years**. CMS proposes to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare or successor websites no sooner than FY 2022 utilizing calculations and displaying results similar to other CAHPS Star Ratings programs. This is not new as CMS has indicated it expected CAHPS Star Ratings to be part of the HQRP at some point in the future but had not previously identified a date.

- **Updates on transition to iQIES**. Hospices are currently required to submit HIS data to CMS using the Quality Improvement and Evaluation System (QIES) Assessment and the

Submission Processing (ASAP) system. The FY 2020 hospice rule finalized the proposal to migrate to a new internet Quality Improvement and Evaluation System (iQIES) that will enable real-time upgrades. CMS is designating the iQIES system as the data submission system for HQRP. It will notify the public about any system migration updates using sub-regulatory mechanisms such as web page postings, listserv messaging, and webinars. (Home health migrated to iQIES in 2020.)

- **Public display of "Quality Measures" and other hospice data for the HQRP**. CMS proposes to publicly report the HVLDL no earlier than May 2022 and to publicly report the HCI, another claims-based measure, no earlier than May 2022. CMS also proposes that in the COVID-19 PHE, it would use three quarters of HIS data for the February 2022 public reporting refresh of Care Compare for the hospice setting. For CAHPS data, CMS proposes to continue to report the most recent eight quarters of available data after the freeze, but not to include the data from the exempted quarters one and two of 2020.

CMS Requests Information on Fast Healthcare Interoperability Resources

As part of its proposed rule, CMS is requesting information on Fast Healthcare Interoperability Resources (FHIR) in support of digital quality measurement in post-acute care quality reporting Programs. A goal of the HQRP is to improve the quality of health care for beneficiaries through measurement, transparency, and public reporting of data.

In October 2017, CMS launched the Meaningful Measures Framework. This framework captures CMS's vision to address health care quality priorities and gaps, including emphasizing digital quality measurement, reducing measurement burden, and promoting patient perspectives, while also focusing on modernization and innovation. The scope of the Meaningful Measures Framework has evolved to Meaningful Measure 2.0 to accommodate the changes in the health care environment, initially focusing on measure and burden reduction to include the promotion of innovation and modernization of all aspects of quality.

CMS sees a need to streamline its approach to data collection, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, improvement, and learning. Therefore, CMS is seeking feedback on future plans to define digital quality measures for the HQRP. CMS is also seeking feedback on the potential use of FHIR for digital quality measurement within the HQRP, aligning, where possible, with other quality programs.

CMS Requests Information on Closing the Health Equity Gap in Post-Acute Care Quality Reporting

As part of its proposed rule, CMS is also requesting information on closing the health equity gap in post-acute care quality reporting programs. Specifically, CMS is requesting information on expanding several related CMS programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for providers and patient. CMS states that its ongoing commitment to closing the health equity gap in the HQRP is demonstrated by the sharing of

information from the Medicare post-acute care public use files (PUF) on Care Compare and seeking to adopt standardized patient assessment data elements (SPADEs) that apply to hospice which include several social determinants of health. While hospice is not included in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, CMS is looking at measures adopted based on that Act, like SPADES, and is examining whether aspects apply to hospice for possible inclusion in HQRP. CMS believes this would help with continuity of care since patients may transition from different post-acute care settings to hospice and it would address a gap in hospice care. Therefore, CMS is seeking comment on the possibility of expanding measure development and adding aspects of SPADEs that could apply to hospice and address gaps in health equity in the HQRP.

Comment Period & Issuance of the FY 2022 Final Rule

CMS's proposed rule will be open for public comment until 5 p.m. on **June 7, 2021**. HCA plans to submit comments on behalf of the membership. Hospice members are encouraged to share with HCA their concerns by e-mailing Patrick Conole at pconole@hcanys.org.

Providers interested in submitting their own comments can do so either electronically, by regular mail, express or overnight mail, hand, or courier and should refer to File Code CMS-1754-P. Electronic comments on the proposed rule can be sent to http://www.regulations.gov (follow the instructions under the "More Search Options" tab). Providers preferring to submit comments by regular mail should send them to: CMS, Department of Health and Human Services, Attention: CMS-1754-P, P.O. Box 8010, Baltimore, MD 21244-1850.

HCA will share with the membership our comments to CMS shortly after they are submitted. HCA expects CMS to post the final rule for the FY 2021 Hospice Wage Index and Payment Rate in the *Federal Register* towards the end of July or early August. HCA will provide the membership with a follow-up Public Policy Memorandum when this occurs.

For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org

Proposed FY 2022 Hospice Wage Index for Rural & Urban Areas

Appendix A

Previous CBSA	New CBSA	County Name	Urban / Rural	CBSA Name	Current FY 2021 Wage Index	FY 2022 Proposed Wage Index New CBSA Designation	% Difference Proposed FY 2022 Wage Index vs Current FY 2021 Wage Index
99933	99933	ALLEGANY	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	CATTARAUGUS	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	CAYUGA	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	CHAUTAUQUA	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	CHENANGO	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	CLINTON	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	COLUMBIA	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	CORTLAND	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	DELAWARE	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	ESSEX	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	FRANKLIN	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	FULTON	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	GENESEE	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	GREENE	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	HAMILTON	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	LEWIS	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	MONTGOMERY	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	OTSEGO	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	ST. LAWRENCE	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	SCHUYLER	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	SENECA	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	STEUBEN	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	SULLIVAN	RURAL	NEW YORK	0.8595	0.8473	-1.42%
99933	99933	WYOMING	RURAL	NEW YORK	0.8595	0.8473	-1.42%
10580	10580	ALBANY	URBAN	Albany-Schenectady-Troy, NY	0.8259	0.8257	-0.02%
10580	10580	RENSSELAER	URBAN	Albany-Schenectady-Troy, NY	0.8259	0.8257	-0.02%
10580	10580	SARATOGA	URBAN	Albany-Schenectady-Troy, NY	0.8259	0.8257	-0.02%
10580	10580	SCHENECTADY	URBAN	Albany-Schenectady-Troy, NY	0.8259	0.8257	-0.02%
10580	10580	SCHOHARIE	URBAN	Albany-Schenectady-Troy, NY	0.8259	0.8257	-0.02%
13780	13780	BROOME	URBAN	Binghamton, NY	0.8343	0.8279	-0.77%
13780	13780	TIOGA	URBAN	Binghamton, NY	0.8343	0.8279	-0.77%
15380	15380	ERIE	URBAN	**Buffalo-Cheektowaga NY**	1.0442	1.0480	0.36%
15380	15380	NIAGARA	URBAN	**Buffalo-Cheektowaga NY**	1.0442	1.0480	0.36%
21300	21300	CHEMUNG	URBAN	Elmira, NY	0.8710	0.9199	5.61%
24020	24020	WARREN	URBAN	Glens Falls, NY	0.8000	0.8000	0.00%
24020	24020	WASHINGTON	URBAN	Glens Falls, NY	0.8000	0.8000	0.00%
27060	27060	TOMPKINS	URBAN	Ithaca, NY	0.9547	1.0885	14.01%
28740	28740	ULSTER	URBAN	Kingston, NY	0.9306	0.9729	4.55%
35004	35004	NASSAU	URBAN	Nassau County-Suffolk County, NY	1.3088	1.2820	-2.05%
35004	35004	SUFFOLK	URBAN	Nassau County-Suffolk County, NY	1.3088	1.2820	-2.05%
35614	35614	BRONX	URBAN	NYC, White Plains, NJ	1.2998	1.3358	2.77%
35614	35614	KINGS	URBAN	NYC, White Plains, NJ	1.2998	1.3358	2.77%
35614	35614	NEW YORK	URBAN	NYC, White Plains, NJ	1.2998	1.3358	2.77%
20524	**35614**	Putnam	URBAN	NYC, White Plains, NJ	1.2998	1.3358	2.77%
35614	35614	QUEENS	URBAN	NYC, White Plains, NJ	1.2998	1.3358	2.77%
35614	35614	RICHMOND	URBAN	NYC, White Plains, NJ	1.2998	1.3358	2.77%
35614	35614	ROCKLAND	URBAN	NYC, White Plains, NJ	1.2998	1.3358	2.77%
35614	35614	WESTCHESTER	URBAN	NYC, White Plains, NJ	1.2998	1.3358	2.77%
20524	39100	Dutchess	Urban	Poughkeepsie-Newburgh-Middletown	1.2046	1.2281	1.95%
35614	39100	Orange	Urban	Poughkeepsie-Newburgh-Middletown	1.2108	1.2281	1.43%
40380	40380	LIVINGSTON	URBAN	Rochester, NY	0.8922	0.9005	0.93%
40380	40380	MONROE	URBAN	Rochester, NY	0.8922	0.9005	0.93%
40380	40380	ONTARIO	URBAN	Rochester, NY	0.8922	0.9005	0.93%
40380	40380	ORLEANS	URBAN	Rochester, NY	0.8922	0.9005	0.93%
40380	40380	WAYNE	URBAN	Rochester, NY	0.8922	0.9005	0.93%
40380	40380	YATES	URBAN	Rochester, NY	0.8922	0.9005	0.93%
45060	45060	MADISON	URBAN	Syracuse, NY	0.9859	1.0202	3.48%
45060	45060	ONONDAGA	URBAN	Syracuse, NY	0.9859	1.0202	3.48%
45060	45060	OSWEGO	URBAN	Syracuse, NY	0.9859	1.0202	3.48%
46540	46540	HERKIMER	URBAN	Utica-Rome, NY	0.9026	0.8966	-0.66%
46540	46540	ONEIDA	URBAN	Utica-Rome, NY	0.9026	0.8966	-0.66%
48060	48060	JEFFERSON	URBAN	Watertown-Fort Drum, NY	0.8876	0.9395	5.85%