DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 418 and 484

[CMS–1754–P]

RIN 0938–AU41

Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This rule proposes updates to the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year 2022. This rule proposes changes to the labor shares of the hospice payment rates, proposes clarifying regulations text changes to the election statement addendum that was implemented on October 1, 2020, includes information on hospice utilization trends and solicits comments regarding hospice utilization and spending patterns. In addition, this rule proposes to make permanent selected regulatory blanket waivers that were issued to Medicare-participating hospice agencies during the COVID–19 public health emergency and updates the hospice conditions of participation. The proposed rule would update the Hospice Quality Reporting Program. The proposed rule requests information on advancing to digital quality measurement, the use of Fast Healthcare Interoperability Resources, addresses the White House Executive Order related to health equity in the Hospice Quality Reporting Program and provides updates to advancing Health Information Exchange. Finally, this rule proposes changes beginning with the January 2022 public reporting for the Home Health Quality Reporting Program to address exceptions related to the COVID–19 public health emergency.

DATES: To be assured consideration, comments must be received at one of the addresses provided below by June 7, 2021.

ADDRESSES: In commenting, refer to file code CMS–1754–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (choose *only one* of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1754–P, P.O. Box 8010, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1754–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

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

For questions regarding the CAHPS® Hospice Survey, contact Debra Dean-Whittaker at (410) 786–0848.

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

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

For questions regarding the hospice quality reporting program, contact Cindy Massuda at (410) 786–0652.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments.

Wage index addenda will be available only through the internet on our website at: (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.*)

I. Executive Summary

A. Purpose

This rule proposes updates to the hospice wage index, payment rates, and cap amount for Fiscal Year (FY) 2022 as required under section 1814(i) of the Social Security Act (the Act). In addition, this rule proposes to rebase the labor shares of the hospice payment rates and proposes clarifying regulations text changes to the election statement addendum requirements finalized in the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484). This rule also includes information on hospice utilization trends and solicits comments regarding hospice utilization and spending patterns. In addition, this rule proposes to make permanent selected regulatory blanket waivers for hospice agencies during the COVID–19 Public Health Emergency (PHE) and proposes revisions to the hospice conditions of participation (CoPs). This rule proposes changes to the Hospice Quality Reporting Program (HQRP), requests information on advancing to digital quality measurement and the use of Fast Healthcare Interoperability Resources (FHIR), addresses the White House Executive Order related to health equity in the HQRP and provides updates on advancing the Health Information Exchange. Finally, this rule proposes changes to the Home Health Quality Reporting Program (HH QRP) to address the January 2022 refresh in accordance with sections 1895(b)(3)(B)(v)(III) and 1899(B)(f) of the Act.

B. Summary of the Major Provisions

Section III.A of this proposed rule includes data analysis on historical hospice utilization trends. The analysis includes data on the number of beneficiaries using the hospice benefit, live discharges, reported diagnoses on hospice claims, Medicare hospice spending, and Parts A, B and D non-hospice spending during a hospice election. In this section, we also solicit comments from the public, including hospice providers as well as patients and advocates, regarding the presented analysis on hospice utilization and spending patterns. We also include questions related to non-hospice spending during a hospice election.

Section III.B of this proposed rule proposes 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 Medicare cost report (MCR) data for freestanding hospice facilities.

Section III.C proposes updates to the hospice wage index and makes the application of the updated wage data budget neutral for all four levels of hospice care. In section III.C of this rule, we also discuss the proposed FY 2022 hospice payment update percentage of 2.3 percent, updates to the hospice payment rates, as well as the updates to

the hospice cap amount for FY 2022 by the hospice payment update percentage of 2.3 percent.

Section III.D proposes clarifying regulations text changes regarding the election statement addendum requirements that were finalized in the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38484).

Section III.E proposes to make permanent selected regulatory blanket waivers that were issued to Medicare-participating hospice agencies during the COVID–19 PHE. We are proposing to revise hospice aide requirements to allow the use of the pseudo-patient for conducting hospice aide competency evaluations. We are also proposing to revise the provisions at § 418.76(h)(1)(iii) to state that if a hospice verifies during an on-site visit the finding of a supervising nurse regarding an area of concern in the performance of a hospice aide, the hospice must conduct and the hospice aide must complete a competency evaluation related to the deficient and related skill(s), in accordance with § 418.76(c).

In section III.F of this rule, we discuss proposals to the HQRP including the addition of claims-based Hospice Care Index (HCI) measure, and Hospice Visits in the Last Days of Life (HVLDL) measure for public reporting; removal of the seven Hospice Item Set (HIS) measures because a more broadly applicable measure, the NQF 3235 HIS Comprehensive Assessment Measure for the particular topic is available and already publicly reported; and further development of, Hospice Outcome and Patient Evaluation (HOPE) assessment instrument. We also provide updates on the public reporting change for one refresh cycle to report less than the standard quarters of data due to the COVID–19 PHE exemptions and adding the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey Star ratings. Additionally, there are requests for information (RFI) on advancing to digital quality measurement and the use of Fast Healthcare Interoperability Resources (FHIR) and on addressing the White House Executive Order related to health equity in the HQRP. In addition, this rule provides updates to advancing Health Information Exchange (HIE). The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care and patient access to their health information.

Finally, in section III.G of this rule, we are proposing changes to the HH QRP to establish that, beginning with the January 2022 through the July 2024 public reporting refresh cycle, we will report fewer quarters of data due to COVID–19 PHE exceptions granted on March 27, 2020. We include this Home Health proposal in this rule because we plan to resume public reporting for the HH QRP with the January 2022 refresh of Care Compare. In order to accommodate the exception of 2020 Q1 and Q2 data, we are proposing to resume public reporting using 3 out of 4 quarters of data for the January 2022 refresh. In order to finalize this proposal in time to release the required preview report related to the refresh, which we release 3 months prior to any given refresh (October 2021), we need the rule containing this proposal to finalize by October 2021.

C. Summary of Impacts

The overall economic impact of this proposed rule is estimated to be $530 million in increased payments to hospices for FY 2022.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of a terminally ill individual and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define ''palliative care'' as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice is compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

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

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

If, in the judgment of the hospice interdisciplinary team, which includes the hospice physician, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home and continue to receive routine home care. Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the

individual can remain at home. Continuous home care may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with the regulations at § 418.204. A minimum of 8 hours of nursing care, or nursing and aide care, must be furnished on a particular day to qualify for the continuous home care rate (§ 418.302(e)(4)).

Hospices must comply with applicable civil rights laws,[1] including section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, under which covered entities must take appropriate steps to ensure effective communication with patients and patient care representatives with disabilities, including the provisions of auxiliary aids and services. Additionally, they must take reasonable steps to ensure meaningful access for individuals with limited English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at: *http://www.hhs.gov/ocr/civilrights.*

B. Services Covered by the Medicare Hospice Benefit

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

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

Upon the implementation of the hospice benefit, the Congress also expected hospices to continue to use volunteer services, though Medicare does not pay for these volunteer services (section 1861(dd)(2)(E) of the Act). As stated in the FY 1983 Hospice Wage Index and Rate Update proposed rule (48 FR 38149), the hospice must have an interdisciplinary group composed of paid hospice employees as well as hospice volunteers, and that ''the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices.'' This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end of life care.

C. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and the regulations in 42 CFR part 418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment based on one of four prospectively-determined rate categories of hospice care (RHC, CHC, IRC, and GIP), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected). This per diem payment is meant to cover all of the hospice services and items needed to manage the beneficiary's care, as required by section 1861(dd)(1) of the Act.

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

1. Omnibus Budget Reconciliation Act of 1989

Section 6005(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) amended section 1814(i)(1)(C) of the Act and provided changes in the methodology concerning updating the daily payment rates based on the hospital market basket percentage increase applied to the payment rates in effect during the previous Federal fiscal year.

2. Balanced Budget Act of 1997

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) established that updates to the hospice payment rates beginning FY 2002 and subsequent FYs be the hospital market basket percentage increase for the FY. Section 4442 of the BBA amended section 1814(i)(2) of the Act, effective for services furnished on or after October 1, 1997, to require that hospices submit claims for payment for hospice care furnished in an individual's home only on the basis of the geographic location at which the service is furnished. Previously, local wage index values were applied based on the geographic location of the hospice provider, regardless of where the hospice care was furnished. Section 4443 of the BBA amended sections 1812(a)(4) and 1812(d)(1) of the Act to provide for hospice benefit periods of two 90-day periods, followed by an unlimited number of 60-day periods.

3. FY 1998 Hospice Wage Index Final Rule

The FY 1998 Hospice Wage Index final rule (62 FR 42860), implemented a new methodology for calculating the

[1] Hospices are also subject to additional Federal civil rights laws, including the Age Discrimination Act, Section 1557 of the Affordable Care Act, and conscience and religious freedom laws.

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

hospice wage index and instituted an annual Budget Neutrality Adjustment Factor (BNAF) so aggregate Medicare payments to hospices would remain budget neutral to payments calculated using the 1983 wage index.

4. FY 2010 Hospice Wage Index Final Rule

The FY 2010 Hospice Wage Index and Rate Update final rule (74 FR 39384) instituted an incremental 7-year phase-out of the BNAF beginning in FY 2010 through FY 2016. The BNAF phase-out reduced the amount of the BNAF increase applied to the hospice wage index value, but was not a reduction in the hospice wage index value itself or in the hospice payment rates.

5. The Affordable Care Act

Starting with FY 2013 (and in subsequent FYs), the market basket percentage update under the hospice payment system referenced in sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(1)(C)(iii) of the Act are subject to annual reductions related to changes in economy-wide productivity, as specified in section 1814(i)(1)(C)(iv) of the Act.

In addition, sections 1814(i)(5)(A) through (C) of the Act, as added by section 3132(a) of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148), required hospices to begin submitting quality data, based on measures specified by the Secretary of the Department of Health and Human Services (the Secretary), for FY 2014 and subsequent FYs. Since FY 2014, hospices that fail to report quality data have their market basket percentage increase reduced by 2 percentage points. Note that with the passage of the Consolidated Appropriations Act, 2021 (hereafter referred to as CAA 2021) (Pub. L. 116–260), the reduction changes to 4 percentage points beginning in FY 2024.

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the PPACA, required, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary's hospice care prior to the 180th day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, the Centers for Medicare & Medicaid Services (CMS) finalized in the FY 2011 Hospice Wage Index final rule (75 FR 70435) that the 180th day recertification and subsequent recertifications would correspond to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the PPACA, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the PPACA could capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determined to be appropriate. The data collected could be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, CMS was required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

In the FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314) it was announced that beginning in 2012, the hospice aggregate cap would be calculated using the patient-by-patient proportional methodology, within certain limits. Existing hospices had the option of having their cap calculated through the original streamlined methodology, also within certain limits. As of FY 2012, new hospices have their cap determinations calculated using the patient-by-patient proportional methodology. If a hospice's total Medicare payments for the cap year exceed the hospice aggregate cap, then the hospice must repay the excess back to Medicare.

7. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185) became law on October 6, 2014. Section 3(a) of the IMPACT Act mandated that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025. In addition, section 3(c) of the IMPACT Act requires medical review of hospice cases involving beneficiaries receiving more than 180 days of care in select hospices that show a preponderance of such patients; section 3(d) of the IMPACT Act contains a new provision mandating that the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025 be updated by the hospice payment percentage update rather than using the consumer price index for urban consumers (CPI–U) for medical care expenditures.

8. FY 2015 Hospice Wage Index and Payment Rate Update Final Rule

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50452) finalized a requirement that the Notice of Election (NOE) be filed within 5 calendar days after the effective date of hospice election. If the NOE is filed beyond this 5-day period, hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing (79 FR 50474). As with the NOE, the claims processing system must be notified of a beneficiary's discharge from hospice or hospice benefit revocation within 5 calendar days after the effective date of the discharge/revocation (unless the hospice has already filed a final claim) through the submission of a final claim or a Notice of Termination or Revocation (NOTR).

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50479) also finalized a requirement that the election form include the beneficiary's choice of attending physician and that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians.

In addition, the FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50496) provided background, described eligibility criteria, identified survey respondents, and otherwise implemented the Hospice Experience of Care Survey for informal caregivers. Hospice providers were required to begin using this survey for hospice patients as of 2015.

Finally, the FY 2015 Hospice Wage Index and Rate Update final rule required providers to complete their aggregate cap determination not sooner than 3 months after the end of the cap year, and not later than 5 months after, and remit any overpayments. Those hospices that fail to submit their aggregate cap determinations on a timely basis will have their payments suspended until the determination is completed and received by the Medicare contractor (79 FR 50503).

9. FY 2016 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), CMS finalized two different payment rates for RHC: A higher per diem base payment rate for the first 60 days of hospice care and a reduced per diem base payment rate for subsequent days of hospice care. CMS also finalized a service intensity add-on (SIA)

payment payable for certain services during the last 7 days of the beneficiary's life. A service intensity add-on payment will be made for the social worker visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last 7 days of life. The SIA payment is in addition to the routine home care rate. The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day (80 FR 47172).

In addition to the hospice payment reform changes discussed, the FY 2016 Hospice Wage Index and Rate Update final rule implemented changes mandated by the IMPACT Act, in which the cap amount for accounting years that end after September 30, 2016 and before October 1, 2025 would be updated by the hospice payment update percentage rather than using the CPI–U (80 FR 47186). In addition, we finalized a provision to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the FY for FY 2017 and thereafter. Finally, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47144) clarified that hospices would have to report all diagnoses on the hospice claim as a part of the ongoing data collection efforts for possible future hospice payment refinements.

10. FY 2017 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52160), CMS finalized several new policies and requirements related to the HQRP. First, CMS codified the policy that if the National Quality Forum (NQF) made non-substantive changes to specifications for HQRP measures as part of the NQF's re-endorsement process, CMS would continue to utilize the measure in its new endorsed status, without going through new notice-and-comment rulemaking. CMS would continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures adopted for the HQRP; determinations about what constitutes a substantive versus non-substantive change would be made on a measure-by-measure basis. Second, we finalized two new quality measures for the HQRP for the FY 2019 payment determination and subsequent years: Hospice Visits when Death is Imminent Measure Pair and Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission (81 FR 52173). The data collection mechanism for both of these measures is the Hospice Item Set (HIS), and the measures were effective April 1, 2017. Regarding the CAHPS® Hospice Survey, CMS finalized a policy that hospices that receive their CMS Certification Number (CCN) after January 1, 2017 for the FY 2019 Annual Payment Update (APU) and January 1, 2018 for the FY 2020 APU will be exempted from the Hospice CAHPS® requirements due to newness (81 FR 52182). The exemption is determined by CMS and is for 1 year only.

11. FY 2020 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38484), we finalized rebased payment rates for CHC and GIP and set those rates equal to their average estimated FY 2019 costs per day. We also rebased IRC per diem rates equal to the estimated FY 2019 average costs per day, with a reduction of 5 percent to the FY 2019 average cost per day to account for coinsurance. We finalized the FY 2020 proposal to reduce the RHC payment rates by 2.72 percent to offset the increases to CHC, IRC, and GIP payment rates to implement this policy in a budget-neutral manner in accordance with section 1814(i)(6) of the Act (84 FR 38496).

In addition, we finalized a policy to use the current year's pre-floor, pre-reclassified hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. Finally, in the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38505), we finalized modifications to the hospice election statement content requirements at § 418.24(b) by requiring hospices, upon request, to furnish an election statement addendum effective beginning in FY 2021. The addendum must list those items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions, increasing coverage transparency for beneficiaries under a hospice election.

12. Consolidated Appropriations Act, 2021

Division CC, section 404 of the CAA 2021 amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket update reduced by the multifactor productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2030. Prior to enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI–U beginning on October 1, 2025. Division CC, section 407 of CAA 2021 revises section 1814(i)(5)(A)(i) to increase the payment reduction for hospices who fail to meet hospice quality measure reporting requirements from two percent to four percent beginning with FY 2024.

III. Provisions of the Proposed Rule

A. Hospice Utilization and Spending Patterns

CMS provides analysis as it relates to hospice utilization such as Medicare spending, utilization by level of care, lengths of stay, live discharge rates, and skilled visits during the last days of life using the most recent, complete claims data. Stakeholders report that such data can be used to educate hospices on Medicare policies to help ensure compliance. Moreover, in response to the Office of Inspector General (OIG) reports highlighting vulnerabilities in the Medicare hospice benefit including hospices engaging in inappropriate billing, not providing needed services and crucial information to beneficiaries in order for them to make informed decisions about their care, [3] we continue to monitor both hospice and non-hospice spending during a hospice election. We are still analyzing the effects of the COVID–19 PHE as it relates to the following routine monitoring analysis and whether those effects are likely to be temporary or permanent and if such effects vary significantly across hospice providers. Therefore, for the purposes of providing routine analysis on utilization and spending, in this proposed rule, we used the most complete data we have from FY 2019.

1. General Hospice Utilization Trends

Since the implementation of the hospice benefit in 1983, there has been substantial growth in hospice utilization. The number of Medicare beneficiaries receiving hospice services has grown from 584,438 in FY 2001 to over 1.6 million in FY 2019. Medicare hospice expenditures have risen from $3.5 billion in FY 2001 to approximately $20 billion in FY 2019.[4] CMS' Office of the Actuary (OACT) projects that aggregate hospice expenditures are expected to continue to increase, by approximately 7.6 percent annually. We note that the

[3] ''Hospice Inappropriately Billed Medicare Over $250 Million for General Inpatient Care'', OEI–02–10–00491, March, 2016. ''Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio'', OEI–02–16–00570, July, 2018.

[4] Source: Analysis of data for FY 2001 through FY 2019 accessed from the Chronic Conditions Data Warehouse (CCW) on January 15, 2021.

average spending per beneficiary has also increased between FY 2010 and FY 2019 from approximately $11,158 in FY 2010 to $12,687 in FY 2019.[5]

The percentage of Medicare decedents who died while receiving services under the Medicare hospice benefit has increased as shown in Table 1.

TABLE 1: Deaths in Hospice by Fiscal Year

FY	Total Deaths of Medicare Beneficiaries	Deaths of Medicare Beneficiaries Using Hospice	Percentage of Deaths in Hospice
2010	1,988,485	866,335	43.6%
2011	2,051,800	924,507	45.1%
2012	2,050,164	958,408	46.7%
2013	2,137,216	1,009,584	47.2%
2014	2,123,163	1,020,318	48.1%
2015	2,223,283	1,073,876	48.3%
2016	2,206,350	1,090,513	49.4%
2017	2,277,731	1,142,935	50.2%
2018	2,328,219	1,183,449	50.8%
2019	2,326,948	1,209,109	52.0%

Source: Analysis of data for FY 2010 through FY 2019 accessed from the CCW on January 15, 2021.
Note: Hospice deaths are counted as any hospice claim with a discharge status code of "40", "41", or "42".

Similar to the increase in the number of beneficiaries using the benefit, the total number of organizations offering hospice services also continues to grow, with for-profit providers entering the market at higher rates than not-for-profit providers. In its March 2020 Report to the Congress, MedPAC stated that for more than a decade, the increasing number of hospice providers is due almost entirely to the entry of for-profit providers. MedPAC also stated that long stays in hospice have been very profitable and this has attracted new provider entrants with revenue-generating strategies specifically targeting those patients expected to have longer lengths of stay.[6] Freestanding hospices continue to dominate the market as a whole. In FY 2019, 68 percent (3,254 out of 4,811) of hospices were for-profit and 21 percent (987 out of 4,811) were non-profit, whereas in FY 2014, 61 percent (2,513 out of 4,108) were for-profit and 25 percent (1,029 out of 4,108) of hospices were non-profit. In FY 2019, for-profit hospices provided approximately 58 percent of all hospice days while non-profit hospices provided 31 percent of all hospice days.[7] Hospices that listed their ownership status as ''Other'', ''Government'' or had an unknown ownership status accounted for the remaining percentage of hospice days.

There have been notable changes in the pattern of diagnoses among Medicare hospice enrollees since the implementation of the Medicare hospice benefit from primarily cancer diagnoses to neurological diagnoses, including Alzheimer's disease and other related dementias (80 FR 25839). Our ongoing analysis of diagnosis reporting finds that neurological and organ-based failure conditions remain the top-reported principal diagnoses. Beneficiaries with these terminal conditions tend to have longer hospice stays, which have historically been more profitable than shorter stays.[8] Table 2 shows the top 20 most frequently reported principal diagnoses on FY 2019 hospice claims.

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[5] Source: Analysis of data for FY 2010 through FY 2019 accessed from the CCW on Jan 15, 2021.

[6] Report to Congress, Medicare Payment Policy. Hospice Services, Chapter 12. MedPAC. March 2020. *http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.*

[7] Source: FY 2014–FY 2019 hospice claims data from CCW on January 15, 2021. December 2020 Provider of Service (POS) File (*https://www.cms.gov/files/zip/posothercsvdec19.zip*).

NOTES: Using the Analytic file, we found there were 4,971 hospices that submitted at least one claim in FY 2019. Of those, we show the frequency of their ownership type as shown in the POS file. For-profit hospices include the ''proprietary'' categories. Non-profit includes the ''voluntary non-profit'' categories. Government includes the ''Government'' categories and the ''Combination Government & Nonprofit'' option. Other represents the ''other'' category. One hospice could not be linked to the POS file and is listed as unknown.

[8] Report to Congress, Medicare Payment Policy. Hospice Services, Chapter 12. MedPAC. March 2020. *http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.*

TABLE 2: Top Twenty Principal Hospice Diagnoses, FY 2019

Rank	ICD-10/Reported Principal Diagnosis	Number of Beneficiaries	Percentage of all Reported Principal Diagnoses
1	G30.9-Alzheimer's disease, unspecified	148,890	9.2%
2	G31.1-Senile degeneration of brain, not elsewhere classified	92,931	5.8%
3	J44.9-Chronic obstructive pulmonary disease, unspecified	84,926	5.3%
4	I50.9-Heart failure, unspecified	60,383	3.7%
5	C34.90-Malignant neoplasm of unspecified part of unspecified bronchus or lung	51,927	3.2%
6	G30.1-Alzheimer's disease with late onset	47,817	3.0%
7	G20-Parkinson's disease	46,781	2.9%
8	I25.10-Atherosclerotic heart disease of native coronary artery without angina pectoris	43,186	2.7%
9	I67.2-Cerebral atherosclerosis	35,355	2.2%
10	I11.0-Hypertensive heart disease with heart failure	28,657	1.8%
11	J44.1-Chronic obstructive pulmonary disease with (acute) exacerbation	28,333	1.8%
12	I63.9-Cerebral infarction, unspecified	27,405	1.7%
13	C61-Malignant neoplasm of prostate	26,652	1.7%
14	I13.0-Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	25,818	1.6%
15	I67.9-Cerebrovascular disease, unspecified	24,467	1.5%
16	N18.6-End stage renal disease	22,727	1.4%
17	C25.9-Malignant neoplasm of pancreas, unspecified	21,700	1.3%
18	C18.9-Malignant neoplasm of colon, unspecified	21,111	1.3%
19	E43-Unspecified severe protein-calorie malnutrition	20,741	1.3%
20	I51.9-Heart disease, unspecified	17,428	1.1%

Source: Analysis of data for FY 2019 accessed from the CCW on January 15, 2021.
Notes: The frequencies shown represent beneficiaries that had a least one claim with the specific ICD–10 code reported as the principal diagnosis. Beneficiaries could be represented multiple times in the results if they had multiple claims during FY 2019 with different principal diagnoses. The percentage column represents the percentage of beneficiary/diagnosis pairs in FY 2019 with a specific ICD-10 code.

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Hospice Utilization by Level of Care

Our analysis shows that there have only been slight changes over time in how hospices have been utilizing the different levels of care. RHC consistently represents the highest percentage of total hospice days as well as the highest percentage of total hospice payments as shown in Tables 3 and 4).

TABLE 3: Percent of Hospice Days by Level of Care, FY 2010 and FY 2019

FY	RHC	CHC	IRC	GIP
2010	97.2%	0.4%	0.3%	2.1%
2019	98.3%	0.2%	0.3%	1.2%

TABLE 4: Percent of Payments to Hospices by Level of Care, FY 2010 and FY 2019

FY	RHC	CHC	IRC	GIP
2010	89.2%	2.0%	0.2%	8.5%
2019	93.8%	0.9%	0.3%	4.9%

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38496), we rebased the payment rates for the CHC, IRC, and GIP levels of care to better align hospice payment with the costs of providing care. We will continue to monitor the effects of these rebased rates to determine if there are any notable shifts in the provision of care or any other perverse utilization patterns that would warrant any program integrity or survey actions.

2. Trends in Hospice Length of Stay, Live Discharges and Skilled Visits in the Last Days of Life Analysis

Eligibility under the Medicare hospice benefit is predicated on the individual being certified as terminally ill. Medicare regulations at § 418.3 define ''terminally ill'' to mean that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. However, we recognize that a beneficiary may be under a hospice election longer than 6 months, as long as there remains a reasonable expectation that the individuals have a life expectancy of 6 months or less. It has always been our expectation that the certifying physicians will use their best clinical judgment, in accordance with the regulations at §§ 418.22 and 418.25, to determine if the individual has a life expectancy of 6 months or less with each certification and recertification.

Hospice Length of Stay

We examined hospice length of stay in three ways: (1) Average length of election, meaning the number of hospice days during a single hospice election at the time of live discharge or death; (2) the median lifetime length of stay, which represents the 50th percentile, and; (3) average lifetime length of stay, which includes the sum of all days of hospice care across all hospice elections. Extremely long lengths of stay influence both the average length of election and average lifetime length of stay. Table 5 shows the average length of election, the median and average lifetime lengths of stay from FYs 2016 through 2019.

TABLE 5: Hospice Length of Stay FYs 2016 - 2019

	FY 2016	FY 2017	FY 2018	FY 2019
Average Length of Election	74 Days	74 Days	75 Days	77 Days
Median Lifetime Length of Stay	19 Days	19 Days	19 Days	20 Days
Average Lifetime Length of Stay	95 Days	95 Days	96 Days	99 Days

Source: Hospice claims data accessed from CCW on January 15, 2021.

Length of stay estimates vary based on the reported principal diagnosis Table 6 lists the top six clinical categories of principal diagnoses reported on hospice claims in FY 2019 along with the corresponding number of hospice discharges. Patients with neurological and organ-based failure conditions (with the exception of kidney disease/kidney failure) tend to have much longer lengths of stay compared to patients with cancer diagnoses.

TABLE 6: Average Length of Stay in Days for Hospice Users in FY 2019

Category	Number of Hospice Users Discharged at the End of FY 2019	Average Length of Election	Median Lifetime Length of Stay	Average Lifetime Length of Stay
Alzheimer's, Dementia, and Parkinson's	210,944	126.9	52	169.0
CVA/Stroke	57,100	114.7	34	148.3
Cancers	290,868	45.7	17	53.5
Chronic Kidney Disease/Kidney Failure	28,130	35.6	8	44.3
Heart (CHF and Other Heart Disease)	210,087	85.4	24	107.6
Lung (COPD and Pneumonias)	112,852	82.2	20	108.0
Other	351,977	64.2	14	82.1
All Diagnoses	1,261,958	77.3	20	98.8

Source: Hospice claims data accessed from CCW on January 15, 2021

Notes: Only beneficiaries whose last day of hospice in FY 2019 was not associated with a discharge status code of ''30'' were counted (''30'' indicates they remained in hospice). We count the start of an election as when a patient begins hospice and is not already within a hospice election. We count elections as ending when we observe a discharge status code other than "30". Lifetime length of stay is determined using all hospice elections over the beneficiary's lifetime.

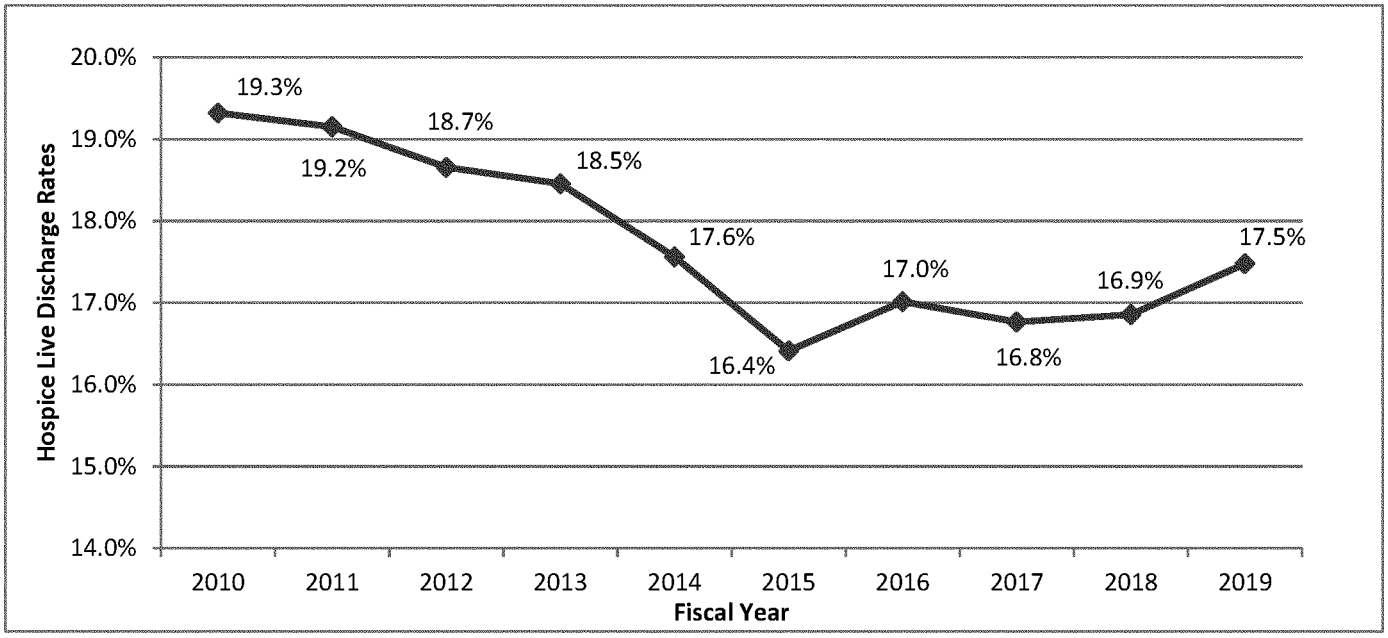
Hospice Live Discharges

Federal regulations limit the circumstances in which a Medicare hospice provider may discharge a patient from its care. In accordance with § 418.26, discharge from hospice care is permissible when the patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause. Hospices may not discharge the patient at their discretion, even if the care may be costly or inconvenient for the hospice. Additionally, an individual or representative may revoke the individual's election of hospice care at any time during an election period in accordance with the regulations at § 418.28. However, at any time thereafter, the beneficiary may re-elect hospice coverage at any other hospice election period that they are eligible to receive. Immediately upon hospice revocation, Medicare coverage resumes for those Medicare benefits previously waived with the hospice election. Only the beneficiary (or representative) can revoke the hospice election. A revocation must be in writing and must specify the effective date of the revocation. A hospice cannot revoke a beneficiary's hospice election, nor is it appropriate for hospices to encourage, request, or demand that the beneficiary or his or her representative revoke his or her hospice election.

From FY 2014 through FY 2019, the average live discharge rate has been approximately 17 percent per year. Of the live discharges in FY 2019, 37.5 percent were because of revocations, 37.2 percent were because the beneficiary was determined to no longer be terminally ill, 10.7 percent were because beneficiaries moved out of the service area without transferring hospices, and 12.9 percent were because beneficiaries transferred to another hospice (see Figure 1). The remaining 1.6 percent were discharged for cause.[9] Figure 1 shows the average annual rates of live discharge rates from FYs 2010 through 2019.

[9] For cause is defined in Chapter 9, Section 20.2.3 of the Hospice Benefit Policy Manual. *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf.*

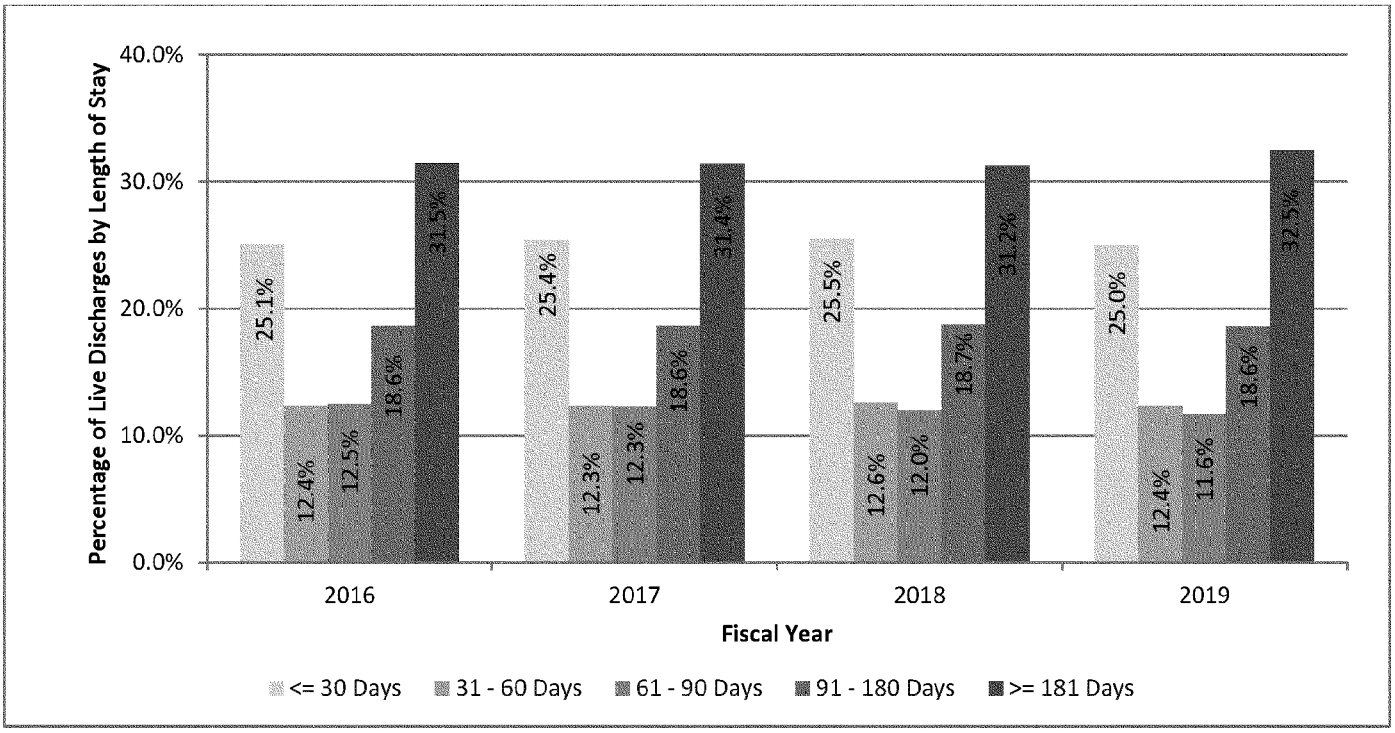
Figure 1: Annual Live Discharge Rates for FYs 2010 - FY 2019



Source: Analysis of data for FY 2010 through FY 2019 accessed from the CCW on January 15, 2021.
Notes: All hospice claims examined list a discharge status code (meaning claims were excluded if they listed status code 30, indicating a continuing patient). Discharges ending in death had a discharge status code of 40, 41, or 42. Any claims not already excluded or indicated a discharge resulting from death were considered live discharges.

Finally, we looked at the distribution of live discharges by length of stay intervals. Figure 2 shows the live discharge rates by length of stay intervals from FY 2016 through FY 2019. We found that the majority of live discharges occur in the first 30 days of hospice care and after 180 days of hospice care. The proportion of live discharges occurring between the lengths of stay intervals was relatively constant from FY 2016 to FY 2019 where approximately 25 percent of live discharges occurred within 30 days of the start of hospice care, and approximately 32 percent occurred after a length of stay over 180 days of hospice care.

Figure 2: Length of Stay Intervals Distribution for Live Discharges, FY 2016 to FY 2019



Source: Analysis of data for FY 2016 through FY 2019 accessed from the CCW on January 15, 2021.
Notes: All hospice claims examined list a discharge status code (meaning claims were excluded if they listed status code 30, indicating they were a continuing patient). Discharges ending in death had a discharge status code of 40, 41, or 42. Any claims not already excluded or indicated a discharge resulting from death were considered live discharges.

Service Intensity Add-On (SIA) Payment

A hospice's costs typically follow a U-shaped curve, with higher costs at the beginning and end of a stay, and lower costs in the middle of the stay. This cost curve reflects hospices' higher service intensity at the time of the patient's admission and the time surrounding the patient's death.[10] In the period immediately preceding death, patient needs typically surge and more intensive services are typically warranted, and where the provision of care would proportionately escalate to meet the increased clinical, emotional, and other needs of the hospice beneficiary and his or her family and caregiver(s).

In the FY 2016 Hospice Rate Update final rule (80 FR 47142), we established two different payment rates for RHC to reflect the cost of providing hospice care throughout the course of a hospice election. We finalized a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for days 61 and later. (80 FR 47172). To reflect higher costs associated with the last 7 days of life, in FY 2016, we implemented the service intensity add-on payment (SIA) for RHC when direct patient care is provided by a RN or social worker during the last 7 of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided on the day of service (up to 4 hours), if certain criteria are met (80 FR 47177). This effort represented meaningful advances in encouraging visits to hospice beneficiaries during the time preceding death and where patient and family needs typically intensify.

To examine the effects of the SIA payment, we analyzed claims since the implementation of the SIA payment to determine if there was an increase in RN and social worker visits in the last seven days of life. In CY 2015 (the year preceding the SIA payment), the percentage of beneficiaries who did not receive a skilled nursing or social worker visit on the last day of life (when the last day of life was RHC) was nearly 23 percent. Our analysis shows a slight decline in the number of beneficiaries who did not receive an RN or social worker visit on the last day of life (when the last day of life was RHC) where the percentage trended downward to just over 19 percent in CYs 2017 to 2019. This trend is similar for the 4 days leading up to the end of life (when the last 4 days of life were RHC), meaning beneficiaries are receiving more skilled nursing and social worker visits during the last days of life since implementation of the SIA payment. Table 7 shows the percentage of decedents not receiving skilled visits at the end of life for CY 2015 through CY 2019.

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[10] Reforming Medicare's Hospice Benefit. MedPAC. March 2009. *http://www.medpac.gov/docs/default-source/reports/Mar09_Ch06.pdf?sfvrsn=0.*

TABLE 7: Percentage of Decedents Not Receiving Skilled Visits at the End of Life (on Routine Home Care Days), Calendar Years (CYs) 2015-2019

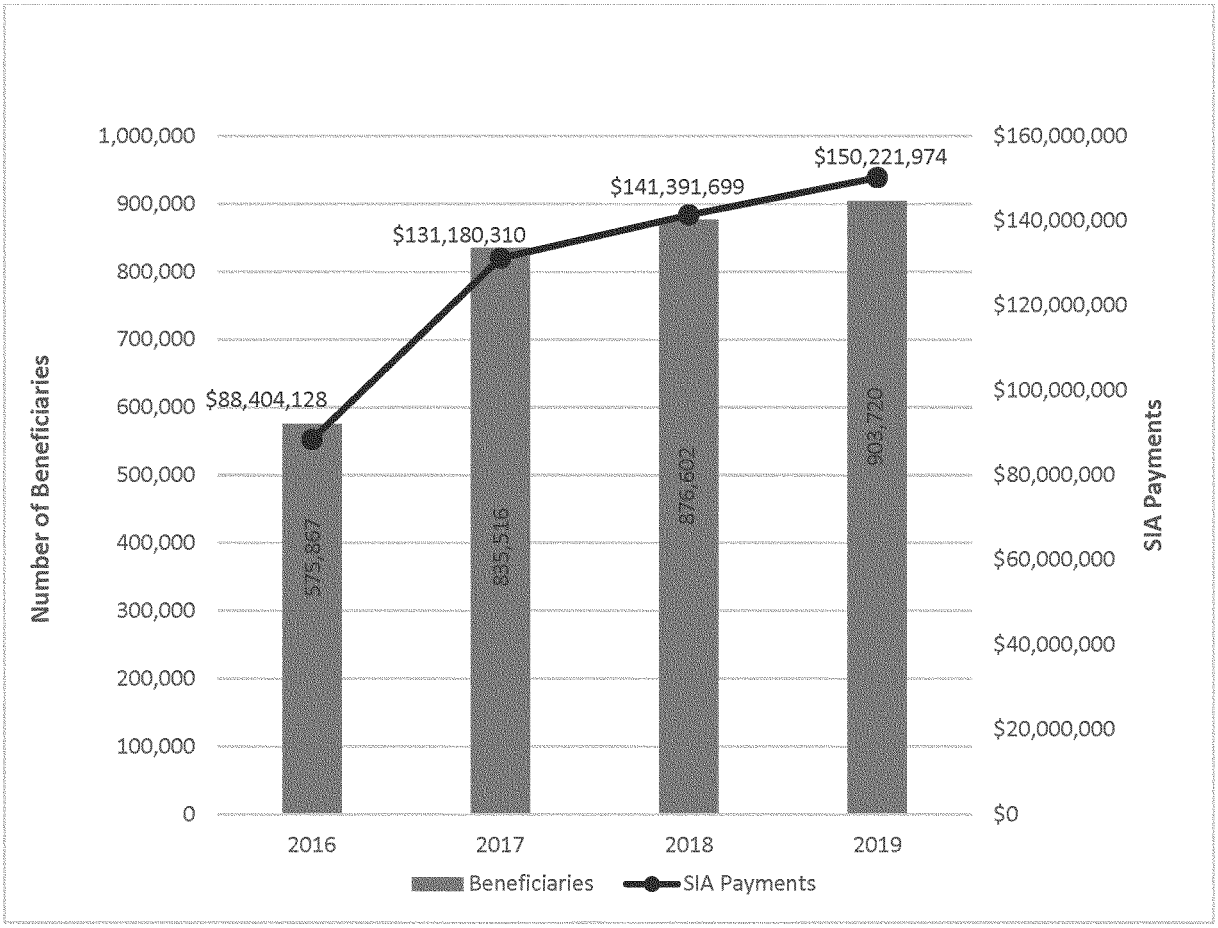
	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
No skilled visits on last day (and last day was RHC)	22.7%	20.4%	19.4%	19.5%	19.6%
No skilled visits on last two days (and last two days were RHC)	11.0%	9.3%	8.3%	7.8%	7.5%
No skilled visits on last three days (and last three days were RHC)	6.8%	5.7%	5.0%	4.6%	4.4%
No skilled visits on last four days (and last four days were RHC)	4.6%	3.8%	3.2%	2.9%	2.8%

Source: Analysis of Medicare hospice claims and administrative data (CY 2015-2019) accessed from the CCW on January 15, 2021.

Note: The FY 2016 payment reform was enacted on January 1, 2016, these analyses use CYs, not FYs, to better align with reform implementation.

SIA payments have increased from FY 2016 through FY 2019 from $88 million to $150 million respectively as shown in Figure 3.

Figure 3: Number of Beneficiaries with Visits that Qualified for SIA Payments, FY 2016 – FY 2019



Source: Analysis of data for FY 2016 through FY 2019 accessed from the CCW on January 15, 2021.
Note: SIA payments were determined by summing the revenue center payments for revenue codes 055x (Nursing) and 056x (Medical Social Services). FY 2016 only includes nine months of SIA payment because the policy started on January 1, 2016.

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To further evaluate the impact of the SIA, we examined the total amount of minutes provided by skilled nurses and social workers in the last 7 days of life and overall there were only modest changes from CY 2015 to CY 2019, as shown in Table 8.[11] MedPAC had examined skilled nurse and social worker minutes in the last 7 days of life from CY 2015 through 2018 in their March 2020 Report to Congress and similarly found little change overall.[12]

[11] *Note:* The SIA technically only applies to registered nurses and non-telephonic social worker visits. The distinction was not widely possible in the claims data prior to the SIA's implementation. For the analyses in this section we examine all skilled nurse and social worker visits, broadly.

[12] Report to Congress, Medicare Payment Policy. Hospice Services, Chapter 12. MedPAC. March 2020. *http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.*

TABLE 8: Average Number of Minutes Provided in the Last Seven Days of Life on Routine Home Care days by Skilled Nurse and Medical Social Workers, CY 2015-2019

Year	Skilled Nurse Minutes	Social Worker Minutes	Total Minutes
2015	48.1	6.0	54.1
2016	49.5	6.5	56.0
2017	50.0	6.6	56.6
2018	50.3	6.6	56.9
2019	50.2	6.7	56.9

Source: Analysis of Medicare hospice claims and administrative data (CY 2015-2019) accessed from the CCW on January 15, 2021.

3. Non-Hospice Spending During a Hospice Election

The Medicare hospice per diem payment amounts were developed to cover all services needed for the palliation and management of the terminal illness and related conditions, as described in section 1861(dd)(1) of the Act. Hospice services provided under a written plan of care (POC) should reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. As referenced in our regulations at § 418.64 and section II.B of this rule, a hospice must routinely provide all core services directly by hospice employees and they must be provided in a manner consistent with acceptable standards of practice. Under the current payment system, hospices are paid for each day that a beneficiary is enrolled in hospice care, regardless of whether services are rendered on any given day.

Additionally, when a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the treatment of the terminal illness and related conditions, except for services provided by the designated hospice and the attending physician. The comprehensive nature of the services covered under the Medicare hospice benefit is structured such that hospice beneficiaries should not have to routinely seek items, services, and/or medications beyond those provided by hospice. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life and we have reiterated since 1983 that ''virtually all'' care needed by the terminally ill individual would be provided by the hospice.

In examining overall non-hospice spending during a hospice election, Medicare paid over $1 billion in non-hospice spending during a hospice election in FY 2019 for items and services under Parts A, B, and D. Medicare payments for non-hospice Part A and Part B items and services received by hospice beneficiaries during a hospice election increased from $583 million in FY 2016 to $692 million in FY 2019 (see Figure 4). This represents an increase in non-hospice Medicare spending for Parts A and B of 18.7 percent. Whereas there is minimal beneficiary cost sharing under the Medicare hospice benefit,[13] non-hospice services received outside of the Medicare hospice benefit are subject to beneficiary cost sharing. In FY 2019, the total beneficiary cost sharing amount was $170 million for Parts A and B.[14]

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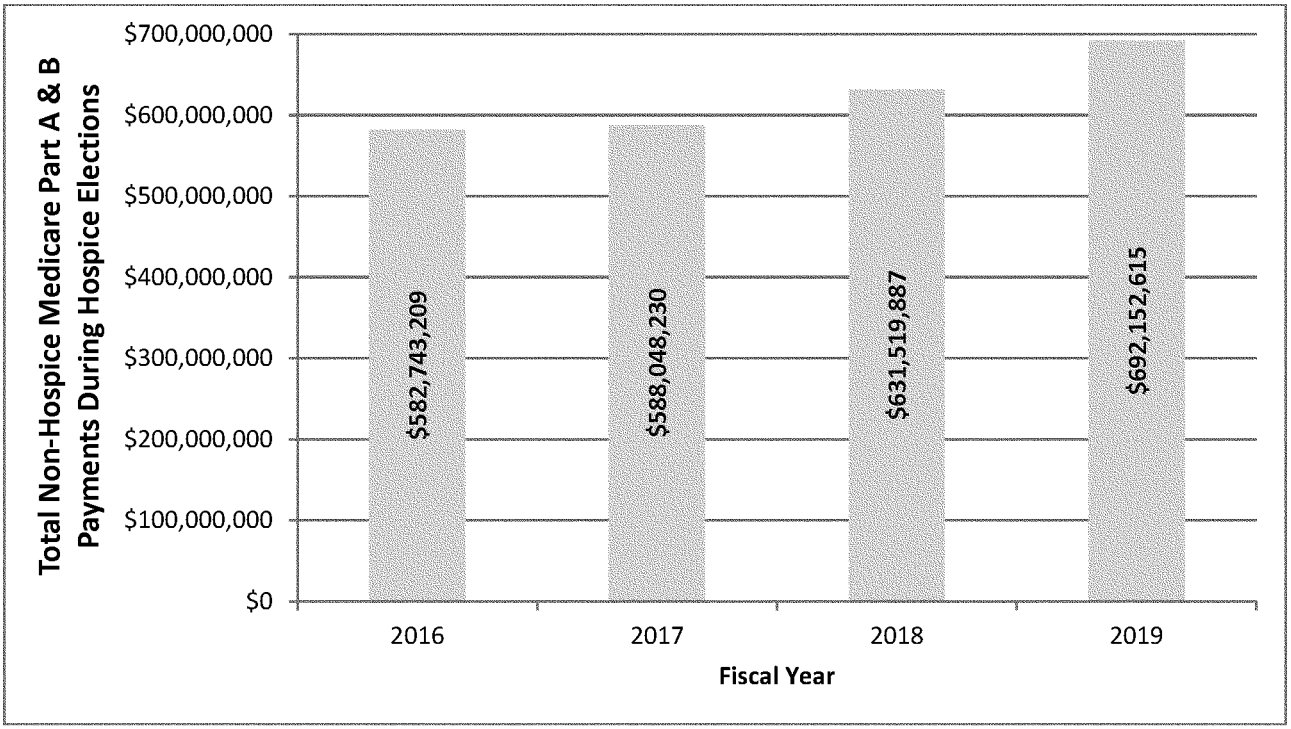
[13] The amount of coinsurance for each prescription approximates 5 percent of the cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed $5. The amount of coinsurance for each respite care day is equal to 5 percent of the payment made by CMS for a respite care.

[14] Part A and B cost sharing is calculated by summing together the deductible and coinsurance amounts for each claim.

Figure 4: Medicare Payments for Non-Hospice Medicare Part A and Part B Items and Services During Hospice Elections, FY 2016 – FY 2019



Source: Analysis of 100% Medicare Part A and B claims analytic files, FY 2016 – 2019, from the CCW, accessed January 15, 2021.

Notes: Payments are based on estimated total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are included. The Medicare paid amounts were equally apportioned across the length of each claim and only the days that overlapped a hospice election (not including hospice admission or live discharge days) were counted.

We also examined non-hospice spending during a hospice election by claim type for Parts A and B, as shown in Table 9.

TABLE 9: Total Medicare Spending Outside the Hospice Benefit during Days of Hospice Service (Excluding Admission/Live Discharge Days) By Claim Type [All Beneficiaries], FY 2016 - FY 2019

Claim Type	FY 2016	FY 2017	FY 2018	FY 2019
Durable Medical Equipment	$38,702,631	$40,740,569	$46,385,066	$54,465,708
Home Health Agency	$19,860,890	$17,491,197	$16,181,405	$16,274,141
Inpatient	$136,926,412	$132,750,947	$139,348,335	$141,717,834
Outpatient	$104,866,171	$109,554,523	$120,840,000	$135,302,250
Physician Billing	$261,085,794	$272,239,518	$296,053,914	$335,142,715
Skilled Nursing Facility	$21,301,311	$15,271,476	$12,711,167	$9,249,967

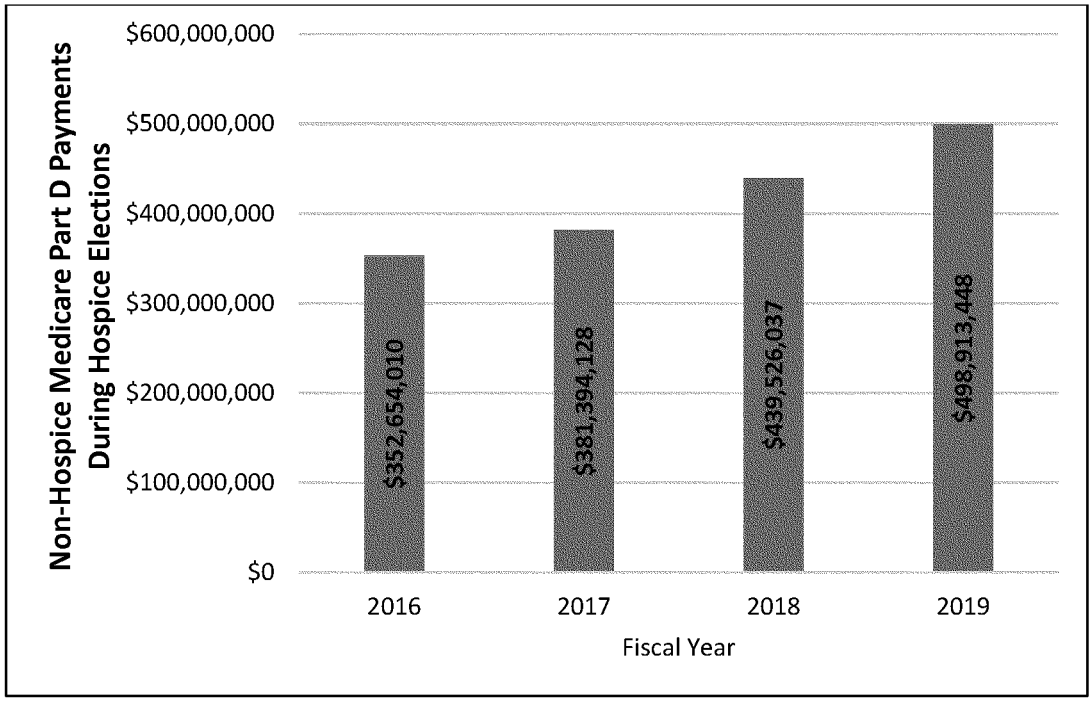
Source: Analysis of 100% Medicare Part A and B claims analytic files, FY 2016 – 2019 from the CCW, accessed January 15, 2021.

Notes: Payments are based on estimated total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are included. The Medicare paid amounts were equally apportioned across the length of each claim and only the days that overlapped a hospice election (not including hospice admission or live discharge days) were counted.

Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and related conditions while the patient is under hospice care. For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment completely unrelated to the terminal illness or related conditions. After a hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, those same drugs may be appropriate to continue as they may offer symptom relief for the palliation and management of the terminal prognosis.[15] Similar to the increase in non-hospice spending during a hospice election for Medicare Parts A and B items and services, non-hospice spending for Part D drugs increased in from $353 million in FY 2016 to $499 million in FY 2019 (Figure 5).

[15] Update on Part D Payment Responsibility for Drugs for Beneficiaries Enrolled in Medicare Hospice. November 2016. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf.*

Figure 5: Total Payments for Non-Hospice Medicare Part D Drugs During Hospice Elections, FY 2016- FY 2019



Source: Analysis of 100% Part D prescription drug events (PDEs), FY 2016 - 2019 from the CCW Virtual Research Data Center (January 15, 2021).

Notes: The Medicare paid amounts were assigned to hospice days based on the service date on the PDE. Only service dates that fell within a hospice election and were not hospice admission or live discharge days were counted. The Medicare paid amount includes the low income cost-sharing subsidy and covered drug plan paid amount on Part D PDEs.

Analysis of Part D prescription drug events (PDEs) data suggests that the current use of prior authorization (PA) by Part D sponsors has reduced Part D program payments for drugs in four targeted categories (analgesics, anti-nauseants, anti-anxiety, and laxatives), which are typically used to treat common symptoms experienced during the end of life. However, under Medicare Part D there has been an increase in hospice beneficiaries filling prescriptions for a separate category of drugs we refer to as maintenance drugs (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf*). Under CMS's current policy, Part D sponsors are not expected to place hospice PA requirements on categories of drugs (other than the four targeted categories listed above) or take special measures beyond their normal compliance and utilization review activities. Under this policy, sponsors are not expected to place PA requirements on maintenance drugs, for beneficiaries under a hospice election, though these drugs may still be subject to standard Part D formulary management practices. This policy was put in place in recognition of the operational challenges associated with requiring PA on all drugs for beneficiaries who have elected hospice and because of the potential barriers to access that could be created by requiring PA on all drugs.[16] Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes. These categories include beta blockers, calcium channel blockers, corticosteroids, and insulin.

Table 10 details the various components of Part D spending for patients receiving hospice care for FY 2019. The portion of the FY 2019 Part D spending that was paid by Medicare is the sum of the Low Income Cost-Sharing Subsidy and the Covered Drug Plan Paid Amount, approximately $499 million. The beneficiary cost sharing amount was approximately $59 million.[17]

[16] Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice. July 18, 2014. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2014-PartD-Hospice-Guidance-Revised-Memo.pdf.*

[17] Part D cost sharing is calculated by summing together the ''the patient pay amount'' and the ''other true out of pocket'' amount that are recorded on the Part D PDE.

TABLE 10: Drug Cost Sources for Hospice Beneficiaries' FY 2019 Drugs Received Through Part D

Component	FY 2019 Expenditures
Patient Pay Amount	$58,509,601
Low Income Cost-Sharing Subsidy	$137,228,459
Other True Out-of Pocket Amount	$1,384,551
Patient Liability Reduction Due to Other Payer Amount	$17,073,388
Covered Drug Plan Paid Amount	$361,684,989
Non-Covered Plan Paid Amount	$12,407,033
Six Payment Amount Totals	**$588,288,021**
Unknown/Unreconciled	$27,560,104
Gross Total Drug Costs, Reported	**$615,848,125**

Source: Analysis of 100% Part D prescription drug events (PDEs), FY 2019, from the CCW, accessed January 15, 2021.
Notes: Payments and costs that occur on hospice admission or live discharge days are excluded from the analysis.

Comment Solicitation on Analysis of Hospice Utilization and Spending Patterns

We are soliciting comments on all aspects of the analysis presented in this proposed rule regarding hospice utilization and spending patterns. Our ongoing monitoring and analysis have shown that the hospice benefit has evolved; originally providing services primarily to patients with cancer, to now primarily patients with neurological conditions and organ-based failure. We are particularly interested in how this change in patient characteristics may have influenced any changes in the provision of hospice services. As mentioned in the above analysis, after the implementation of the SIA in FY 2016, the number of beneficiaries who did not receive an RN or social worker visit on the last day of has decreased. We are soliciting comments regarding skilled visits in the last week of life, particularly, what factors determine how and when visits are made as an individual approaches the end of life.

Given the comprehensive and holistic nature of the services covered under the Medicare hospice benefit, we continue to expect that hospices are providing virtually all of the care needed by terminally ill individuals. However, the analysis of non-hospice spending during a hospice election indicates a continuing trend where there is a potential ''unbundling'' of items, services, and drugs from the Medicare hospice benefit. That is, there may be items, services, and drugs that should be covered under the Medicare hospice benefit but are being paid under other Medicare benefits. We are soliciting comments as to how hospices make determinations as to what items, services and drugs are related versus unrelated to the terminal illness and related conditions. That is, how do hospices define what is unrelated to the terminal illness and related conditions when establishing a hospice plan of care. Likewise, we are soliciting comments on what other factors may influence whether or how certain services are furnished to hospice beneficiaries. Finally, we are interested in stakeholder feedback as to 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 that the care needs of beneficiaries who have elected the hospice benefit are met.

B. FY 2022 Proposed Labor Shares

1. Background

The labor share for CHC and RHC of 68.71 percent was established with the FY 1984 Hospice benefit implementation based on the wage/nonwage proportions specified in Medicare's limit on home health agency costs (48 FR 38155 through 38156). The labor shares for IRC and GIP are currently 54.13 percent and 64.01 percent, respectively. These proportions were based on skilled nursing facility wage and nonwage cost limits and skilled nursing facility costs per day (48 FR 38155 through 38156; 56 FR 26917).

For the FY 2022 proposed rule, we are proposing to rebase and revise the labor shares for CHC, RHC, IRC and GIP using MCR data for freestanding hospices (CMS Form 1984–14, OMB NO. 0938–0758 [18]) for 2018. We are proposing to continue to establish separate labor shares for CHC, RHC, IRC, and GIP and base them on the calculated compensation cost weights for each level of care from the 2018 MCR data. We describe our proposed methodology for deriving the compensation cost weights for each level of care using the MCR data below. We note that we did explore the possibility of using facility-based hospice MCR data to calculate the compensation cost weights; however, very few providers passed the Level I edits (as described in more detail below) and so these reports were not usable.

1. Proposed Methodology for Calculating Compensation Costs

We are proposing to derive a compensation cost weight for each level of care that consists of five major components: (1) Direct patient care salaries and contract labor costs, (2) direct patient care benefits costs, (3) other patient care salaries, (4) overhead salaries, and (5) overhead benefits costs. For each level of care, we are proposing to use the same methodology to derive the components; however, for the (1)

[18] Hospice Facility Cost Report. *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-1984-14.*

direct patient care salaries and (3) other patient care salaries, we are proposing to use the MCR worksheet that is specific to that level of care (that is, Worksheet A–1 for CHC, Worksheet A–2 for RHC, Worksheet A–3 for IRC, and Worksheet A–4 for GIP).

(1) Direct Patient Care Salaries and Contract Labor Costs

Direct patient care salaries and contract labor costs are costs associated with medical services provided by medical personnel including but not limited to physician services, nurse practitioners, registered nurses, and hospice aides. We are proposing to define direct patient care salaries and contract labor costs to be equal to costs reported on Worksheet A–1 (for CHC) or Worksheet A–2 (for RHC) or Worksheet A–3 (for IRC) or Worksheet A–4 (for GIP), column 7, for lines 26 through 37.

(2) Direct Patient Care Benefits Costs

We are proposing that direct patient care benefits costs for CHC would be equal to Worksheet B, column 3, line 50, for RHC are equal to Worksheet B, column 3, line 51, for IRC are equal to Worksheet B, column 3, line 52, and for GIP are equal to Worksheet B, column 3, line 53.

(3) Other Patient Care Salaries

Other patient care salaries are those salaries attributable to patient services including but not limited to patient transportation, labs, and imaging services. These salaries, reflecting all levels of care, are reported on Worksheet A, column 1, lines 38 through 46 and then are further disaggregated for CHC, RHC, IRC, and GIP on Worksheets A–1, A–2, A–3, and A–4, respectively, on column 1 (salaries), lines 38 through 46. Our analysis, however, found that many providers were not reporting salaries on the detailed level of care worksheets (A–1, A–2, A–3, A–4, column 1), but rather reporting total costs (reflecting salary and non-salary costs) for these services for each level of care on Worksheets A–1, A–2, A–3, A–4, column 7. Therefore, we are proposing to estimate other patient care salaries attributable to CHC, RHC, IRC, and GIP by first calculating the ratio of total facility (reflecting all levels of care) other patient care salaries (Worksheet A, column 1, lines 38 through 46) to total facility other patient care total costs (Worksheet A, column 7, lines 38 through 46). For CHC, we are proposing to then multiply this ratio by other patient care total costs for CHC (Worksheet A–1 column 7, lines 38 through 46). For RHC, we are proposing to multiply this ratio by total other patient care costs for RHC (Worksheet A–2, column 7, lines 38 through 46). For IRC, we are proposing to multiply this ratio by total other patient care costs for IRC (Worksheet A–3, column 7, lines 38 through 46). For GIP, we are proposing to multiply this ratio by total other patient care costs for GIP (Worksheet A–4, column 7, lines 38 through 46). This proposed methodology assumes that the proportion of salary costs to total costs for other patient care services is consistent for each of the four levels of care.

(4) Overhead Salaries

The MCR captures total overhead costs (including but not limited to administrative and general, plant operations and maintenance, and housekeeping) attributable to each of the four levels of care. To estimate overhead salaries for each level of care, we first propose to calculate noncapital non-benefit overhead costs for each level of care to be equal to Worksheet B, column 18, less the sum of Worksheet B, columns 0 through 3, for line 50 (CHC), or line 51 (RHC) or line 52 (IRC) or line 53 (GIP). We then are proposing to multiply these non-capital non-benefit overhead costs for each level of care times the ratio of total facility overhead salaries (Worksheet A, column 1, lines 4 through 16) to total facility non-capital non-benefit overhead costs (which is equal to Worksheet B, column 18 (total costs), line 101 less the sum of Worksheet B, columns 0 (direct patient care costs), column 1 (fixed capital), column 2 (moveable capital) and column 3 (employee benefits), line 101).

(5) Overhead Benefits Costs

To estimate overhead benefits costs for each level of care, we are proposing a similar methodology to overhead salaries. For each level of care, we are proposing to calculate noncapital overhead costs for each level of care to be equal to Worksheet B, column 18, less the sum of Worksheet B, columns 0 through 2, for line 50 (CHC), or line 51 (RHC) or line 52 (IRC) or line 53 (GIP). We then are proposing to multiply these non-capital overhead costs for each level of care times the ratio of total facility overhead benefits (Worksheet B, column 3, lines 4 through 16) to total facility noncapital overhead costs (Worksheet B, column 18, line 101 less the sum of Worksheet B, columns 0 through 2, line 101). This proposed methodology assumes the ratio of total overhead benefit costs to total noncapital overhead costs is consistent among all four levels of care.

(6) Total Compensation Costs and Total Costs

To calculate the compensation costs for each provider, we are proposing to then sum each of the costs estimated in steps (1) through (5) to derive total compensation costs for CHC, RHC, IRC, and GIP. We are proposing that total costs for CHC are equal to Worksheet B, column 18, line 50, for RHC are equal to Worksheet B, column 18, line 51, for IRC would be equal to Worksheet B, column 18, line 52, and for GIP are equal to Worksheet B, column 18, line 53.

2. Proposed Methodology for Deriving Compensation Cost Weights

To derive the compensation cost weights for each level of care, we first are proposing to begin with a sample of providers who met new Level I edit conditions that required freestanding hospices to fill out certain parts of their cost reports effective for freestanding hospice cost reports with a reporting period that ended on or after December 31, 2017.[19] Specifically, we required the following costs to be greater than zero: Fixed capital costs (Worksheet B, column 0, line 1), movable capital costs (Worksheet B, column 0, line 2), employee benefits (Worksheet B, column 0, line 3), administrative and general (Worksheet B, column 0, line 4), volunteer service coordination (Worksheet B, column 0, line 13), pharmacy and drugs charged to patients (sum of Worksheet B, column 0, line 14 and Worksheet A, column 7, line 42.50), registered nurse costs (Worksheet A, column 7, line 28), medical social service costs (Worksheet A, column 7, line 33), hospice aide and homemaker services costs (Worksheet A, column 7, line 37), and durable medical equipment (Worksheet A, column 7, line 38). Applying these Level I edits to the 2018 freestanding hospice MCRs resulted in 3,345 providers that passed the edits (four were excluded).

Then, for each level of care separately, we are proposing to further trim the sample of MCRs. We outline our proposed trimming methodology using CHC as an example. Specifically, for CHC, we propose that total CHC costs (Worksheet B, column 18, line 50) and CHC compensation costs to be greater than zero. We also propose that CHC direct patient care salaries and contract labor costs per day would be greater

[19] Medicare Department of Health and Human Services (DHHS) Provider Reimbursement Manual—Part 2, Provider Cost Reporting Forms and Instructions, Chapter 43, Form CMS–1984–14. April 13, 2018. *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3P243.pdf.*

than 1. We also propose to exclude those providers whose CHC compensation costs were greater than total CHC costs.

For the IRC and GIP compensation cost weights, we are proposing to only use those MCRs from providers that provided inpatient services in their facility. Therefore, we are proposing to exclude providers that reported costs greater than zero on Worksheet A–3, column 7, line 25 (Inpatient Care—Contracted) for IRC and Worksheet A–4, column 7, line 25 (Inpatient Care—Contracted) for GIP. The facilities that remained after this trim reported detailed direct patient care costs and other patient care costs for which we could then derive direct patient care salaries and other patient care salaries per the methodology described earlier. This additional trim resulted in a sample that consists of approximately 20 percent of IRP providers and 28 percent of GIP providers that passed both the Level I edits and the trims that required total costs and compensation costs to be greater than zero, and direct patient care salaries and contract labor costs per day to be greater than 1, as well as total costs to be greater than compensation costs.

Finally, to derive the proposed compensation cost weights for each level of care for each provider, we are proposing to divide compensation costs for each level of care by total costs for each level of care. We are proposing to then trim the data for each level of care separately to remove outliers. Following our example for CHC, we are proposing to simultaneously remove those providers whose total CHC costs per day fall in the top and bottom one percent of total CHC costs per day for all CHC providers as well remove those providers whose compensation cost weight falls in the top and bottom five percent of compensation cost weights for all CHC providers. We then sum the CHC compensation costs and total CHC costs of the remaining providers, yielding a proposed compensation cost weight for CHC.

Since we have to limit our sample for IRC and GIP compensation cost weights to those hospices providing inpatient services in their facility, we conducted sensitivity analysis to test for the representative of this sample by reweighting compensation cost weights using data from the universe of freestanding providers that reported either IRC or GIP total costs. For example, we calculated reweighted compensation cost weights by ownership-type (proprietary, government and nonprofit), by size (based on RHC days) and by region. Our reweighted compensation cost weights for IRC and GIP were similar (less than one percentage point in absolute terms) to our proposed compensation cost weights for IRC and GIP (as shown in Table 11) and, therefore, we believe our sample is representative of freestanding hospices providing inpatient hospice care.

Table 11 provides the proposed labor share for each level of care based on the compensation cost weights we derived using our proposed methodology described previously. We are proposing the labor shares be equal to three decimal places consistent with the labor shares used in other Prospective Payment Systems (PPS) (such as the inpatient prospective payment system (IPPS) and the Home Health Agency PPS). We invite comments on our proposed methodology to derive the labor shares for each level of care.

TABLE 11: Proposed and Current Labor shares by Level of Care

	Proposed Labor shares	Current Labor shares
Continuous Home Care	74.6%	68.71%
Routine Home Care	64.7%	68.71%
Inpatient Respite Care	60.1%	54.13%
General Inpatient Care	62.8%	64.01%

C. Proposed Routine FY 2022 Hospice Wage Index and Rate Update

1. Proposed FY 2022 Hospice Wage Index

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

In general, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On March 6, 2020, OMB issued Bulletin No. 20–01, which provided updates to and superseded OMB Bulletin No. 18–04 that was issued on September 14, 2018. The attachments to OMB Bulletin No. 20–01 provided detailed information on the update to statistical areas since September 14, 2018, and were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2017 and July 1, 2018. (For a copy of this bulletin, we refer readers to the following website: *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*). In OMB Bulletin No. 20–01, OMB announced one new Micropolitan Statistical Area, one new component of an existing Combined Statistical Are and changes to New England City and Town Area (NECTA) delineations. In the FY 2021 Hospice Wage Index final rule (85 FR 47070) we stated that if appropriate, we would propose any updates from OMB Bulletin No. 20–01 in future rulemaking. After reviewing OMB Bulletin No. 20–01, we have determined that the changes in Bulletin 20–01 encompassed delineation changes

that would not affect the Medicare wage index for FY 2022. Specifically, the updates consisted of changes to NECTA delineations and the redesignation of a single rural county into a newly created Micropolitan Statistical Area. The Medicare wage index does not utilize NECTA definitions, and, as most recently discussed in the FY 2021 Hospice Wage Index final rule (85 FR 47070), we include hospitals located in Micropolitan Statistical areas in each state's rural wage index. Therefore, while we are proposing to adopt the updates set forth in OMB Bulletin No. 20–01 consistent with our longstanding policy of adopting OMB delineation updates, we note that specific wage index updates would not be necessary for FY 2022 as a result of adopting these OMB updates. In other words, these OMB updates would not affect any geographic areas for purposes of the wage index calculation for FY 2022.

In the FY 2020 Hospice Wage Index final rule (84 FR 38484), we finalized the proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we finalized the proposal to adopt the revised OMB delineations with a 5 percent cap on wage index decreases, where the estimated reduction in a geographic area's wage index would be capped at 5 percent in FY 2021 and no cap would be applied to wage index decreases for the second year (FY 2022). 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 proposed FY 2022 hospice wage index would not include a cap on wage index decreases and would not take into account any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The 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.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the Core-Based Statistical Areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2022, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia. The FY 2022 adjusted wage index value for Hinesville-Fort Stewart, Georgia is 0.8649.

There exist some geographic areas where there were no hospitals, and thus, no hospital wage data on which to base the calculation of the hospice wage index. In the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term ''contiguous'' means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2022, we propose to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. As previously discussed, the adjusted pre-floor, pre-reclassified hospital wage index values below 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15, which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8. The proposed hospice wage index applicable for FY 2022 (October 1, 2021 through September 30, 2022) is available on our website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.*

2. Proposed FY 2022 Hospice Payment Update Percentage

Section 4441(a) of the BBA (Pub. L. 105–33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient market basket percentage increase for that FY. CMS currently uses 2014-based IPPS operating and capital market baskets to update the market basket percentage. In the FY 2022 IPPS proposed rule [20] CMS is proposing to rebase and revise the IPPS market baskets to reflect a 2018 base year. We refer stakeholders to the FY 2022 IPPS proposed rule for further information.

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP).

The proposed hospice payment update percentage for FY 2022 is based on the current estimate of the proposed 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 2020). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the proposed inpatient hospital market basket update

[20] IPPS Regulations and Notices. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/IPPS-Regulations-and-Notices.*

for FY 2022 of 2.5 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.2 percentage points for FY 2022). In effect, the proposed hospice payment update percentage for FY 2022 would be 2.3 percent. If more recent data becomes available after the publication of this proposed rule and before the publication of the final rule (for example, more recent estimates of the inpatient hospital market basket update and MFP adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage for FY 2022 in the final rule.

Currently, the labor portion of the hospice payment rates are as follows: For RHC, 68.71 percent; for CHC, 68.71 percent; for GIP, 64.01 percent; and for IRC, 54.13 percent. As discussed in section III.B of this proposed rule, we are proposing to rebase and revise the labor shares for RHC, CHC, GIP and IRC using MCR data for freestanding hospices (CMS Form 1984–14, OMB Control Number 0938–0758) for 2018. We are proposing the labor portion of the payment rates to be: For RHC, 64.7 percent; for CHC, 74.6 percent; for GIP, 62.8 percent; and for IRC, 60.1 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. Therefore, we are proposing the non-labor portion of the payment rates to be as follows: For RHC, 35.3 percent; for CHC, 25.4 percent; for GIP, 37.2 percent; and for IRC, 39.9 percent.

3. Proposed FY 2022 Hospice Payment Rates

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

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

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. Typically, the wage index standardization factor is calculated using the most recent, complete hospice claims data available. However, due to the COVID–19 PHE, we looked at using the previous fiscal year's hospice claims data (FY 2019) to determine if there were significant differences between utilizing 2019 and 2020 claims data. The difference between using FY 2019 and FY 2020 hospice claims data was minimal. Therefore, we will continue our practice of using the most recent, complete hospice claims data available; that is we are using FY 2020 claims data for the FY 2022 payment rate updates. In order to calculate the wage index standardization factor, we simulate total payments using FY 2020 hospice utilization claims data with the FY 2021 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, and a 5 percent cap on wage index decreases) and FY 2021 payment rates (that include the current labor shares) and compare it to our simulation of total payments using the FY 2022 hospice wage index (with hospice floor, without the 5 percent cap on wage index decreases) and FY 2021 payment rates (that include the current labor shares). By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2021 wage index and payment rates for each level of care by the FY 2022 wage index and FY 2021 payment rates, we obtain a wage index standardization factor for each level of care. In order to calculate the labor share standardization factor we simulate total payments using FY 2020 hospice utilization claims data with the FY 2022 hospice wage index and the current labor shares and compare it to our simulation of total payments using the FY 2022 hospice wage index with the proposed revised labor shares. The wage index and labor share standardization factors for each level of care are shown in the Tables 12 and 13.

The proposed FY 2022 RHC rates are shown in Table 12. The proposed FY 2022 payment rates for CHC, IRC, and GIP are shown in Table 13.

TABLE 12: Proposed FY 2022 Hospice RHC Payment Rates

Code	Description	FY 2021 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	Labor Share Standardization Factor	Proposed FY 2022 Hospice Payment Update	Proposed FY 2022 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 13: Proposed FY 2022 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2021 Payment Rates	Wage Index Standardization Factor	Labor Share Standardization Factor	Proposed FY 2022 Hospice Payment Update	Proposed FY 2022 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care	$1,432.41 ($59.68 per hour)	0.9998	1.0005	X 1.023	$1,465.79 ($61.07 per hour)
655	Inpatient Respite Care	$461.09	1.0007	1.0051	X 1.023	$474.43
656	General Inpatient Care	$1,045.66	1.0013	0.9993	X 1.023	$1,070.35

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012, and submit that quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. The proposed FY 2022 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2022 hospice payment update percentage of 2.3 percent minus 2 percentage points. These rates are shown in Tables 14 and 15.

TABLE 14: Proposed FY 2022 Hospice RHC Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2021 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	Labor Share Standardization Factor	Proposed FY 2022 Hospice Payment Update of 2.3% minus 2 percentage points = +0.3%	Proposed FY 2022 Payment Rates
651	Routine Home Care (days 1-60)	$199.25	1.0004	1.0002	0.9993	X 1.003	$199.83
651	Routine Home Care (days 61+)	$157.49	1.0005	1.0001	0.9988	X 1.003	$157.87

TABLE 15: Proposed FY 2022 Hospice CHC, IRC, and GIP Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2021 Payment Rates	Wage Index Standardization Factor	Labor Share Standardization Factor	Proposed FY 2022 Hospice Payment Update of 2.3% minus 2 percentage points = +0.3%	Proposed FY 2022 Payment Rates
652	Continuous Home Care Full Rate= 24 hours of care	$1,432.41 ($59.68 / per hour)	0.9998	1.0005	X 1.003	$1,437.14 ($59.88 per hour)
655	Inpatient Respite Care	$461.09	1.0007	1.0051	X 1.003	$465.16
656	General Inpatient Care	$1,045.66	1.0013	0.9993	X 1.003	$1,049.43

4. Proposed Hospice Cap Amount for FY 2022

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (Pub. L. 113–185). Specifically, we stated that for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. Division CC, section 404 of the CAA 2021 has extended the accounting years impacted by the adjustment made to the hospice cap calculation until 2030. Therefore, for accounting years that end after September 30, 2016 and before October 1, 2030, the hospice cap amount is updated by the hospice payment update percentage rather than using the CPI–U. As a result of the changes mandated by Division CC, section 404 of the CAA 2021, we are proposing conforming regulation text changes at § 418.309 to reflect the new language added to section 1814(i)(2)(B) of the Act.

The proposed hospice cap amount for the FY 2022 cap year will be $31,389.66, which is equal to the FY 2021 cap amount ($30,683.93) updated by the proposed FY 2022 hospice payment update percentage of 2.3 percent.

D. Proposed Clarifying Regulation Text Changes for the Hospice Election Statement Addendum

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we finalized modifications to the hospice election statement content requirements at § 418.24(b) to increase coverage transparency for patients under a hospice election. These changes included a new condition for payment requiring a hospice, upon request, to provide the beneficiary (or representative) an election statement addendum (hereafter called ''the addendum'') outlining the items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. We stated in that final rule that the addendum is intended to complement the Hospice Conditions of Participation (CoPs) at § 418.52(a), which require hospices to verbally inform beneficiaries, at the time of hospice election, of the services covered under the Medicare hospice benefit, as well as the limitations of such services (84 FR 38509). The requirements at §§ 418.24(b) and 418.52(a) ensure that beneficiaries are aware of any items, services, or drugs they would have to seek outside of the benefit, as well as their potential out-of-pocket costs for hospice care, such as co-payments and/or coinsurance.

Section 418.24(c) sets forth the elements that must be included on the addendum:

1. The addendum must be titled ''Patient Notification of Hospice Non-Covered Items, Services, and Drugs'';

2. Name of the hospice;

3. Beneficiary's name and hospice medical record identifier;

4. Identification of the beneficiary's terminal illness and related conditions;

5. A list of the beneficiary's current diagnoses/conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs, not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions;

6. A written clinical explanation, in language the beneficiary and his or her representative can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation must be accompanied by a general statement that the decision as to what conditions, items, services, or drugs are unrelated is made for each individual patient, and that the beneficiary should share this clinical explanation with other health care providers from which he or she seeks services unrelated to his or her terminal illness and related conditions;

7. References to any relevant clinical practice, policy, or coverage guidelines;

8. Information on the following:

a. Purpose of the addendum

b. patient's right to immediate advocacy

9. Name and signature of the Medicare hospice beneficiary (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the beneficiary's agreement with the hospice's determinations.

The hospice is required to furnish the addendum in writing in an accessible format,[23] so the beneficiary (or representative) can understand the information provided, make treatment decisions based on that information, and share such information with non-hospice providers rendering un-related items and services to the beneficiary. Therefore, the format of the addendum

[23] English and Spanish Version of the Hospice Addendum Model. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice.*

must be usable for the beneficiary and/or representative. Although we stated in the FY 2020 Hospice Wage Index and Payment Rate Update that hospices may develop their own election statement addendum (84 FR 38507), we posted a modified model election statement and addendum on the Hospice Center web page,[21] along with the publication of the FY 2021 Hospice Wage Index and Payment Rate Update final rule (85 FR 47070). The intent was to provide an illustrative example as hospices can modify and develop their own forms to meet the content requirements. In the FY 2021 Hospice Wage Index and Payment Rate Update final rule, we stated that most often we would expect the addendum would be in a hard copy format the beneficiary or representative can keep for his or her own records, similar to how hospices are required by the hospice CoPs at § 418.52(a)(3) to provide the individual a copy of the notice of patient rights and responsibilities (85 FR 47091). The hospice CoPs at § 418.104(a)(2) state that the patient's record must include ''signed copies of the notice of patient rights in accordance with § 418.52.'' Likewise, since the addendum is part of the election statement as set forth in § 418.24(b)(6), then it is required to be part of the patient's record (if requested by the beneficiary or representative). The signed addendum is only acknowledgement of the beneficiary's (or representative's) receipt of the addendum (or its updates) and the payment requirement is considered met if there is a signed addendum (and any signed updates) in the requesting beneficiary's medical record with the hospice. We believe that a signed addendum connotes 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, we expect 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. 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.

[21] Hospice Center web page. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.*

Though we did not propose any changes to the election statement addendum content requirements at § 418.24(c), or the October 1, 2020 effective date, in the FY 2021 Hospice Wage Index and Payment Rate Update proposed rule, we solicited comments on the usefulness of the modified model election statement and addendum posted on the Hospice Center web page (85 FR 20949). In the FY 2021 Hospice Wage Index and Payment Rate Update final rule (85 FR 47093), we responded to comments received, and stated that, as finalized in the FY 2020 Hospice Wage Index and Payment Rate Update final rule, the hospice election statement addendum will remain a condition for payment that is met when there is a signed addendum (and its updates) in the beneficiary's hospice medical record.

Since its implementation on October 1, 2020, CMS has received additional inquiries from stakeholders asking for clarification on certain aspects of the addendum. We appreciate and understand the importance of provider input and involvement in ensuring that this document is effective in increasing coverage transparency for beneficiaries. Therefore, we are providing clarification on, and proposing modifications to, certain signature and timing requirements and proposing corresponding clarifying regulations text changes.

Currently the regulations at § 418.24(c) require that if a beneficiary or his or her representative requests the addendum at the time of the initial hospice election (that is, at the time of admission to hospice), the hospice must provide this information, in writing, to the individual (or representative) within 5 days from the date of the election. Hospices have reported that beneficiaries or representatives sometimes do not request the addendum at the time of election, but rather within the 5 days after the effective date of the election. In these situations, the regulations require the hospice to provide the addendum within 3 days, as the beneficiary requested the addendum during the course of care. However, in accordance with § 418.54(b), the hospice interdisciplinary group (IDG), in consultation with the individual's attending physician (if any), must complete the hospice comprehensive assessment no later than 5 calendar days after the election of hospice care. In some instances, this may mean that the hospice must furnish the addendum prior to completion of the comprehensive assessment. The comprehensive assessment includes all areas of hospice care related to the palliation and management of a beneficiary's terminal illness. This assessment is necessary because it provides an overview of the items, services and drugs that the patient is already utilizing as well as helps determine what the hospice may need to add in order to treat the patient throughout the dying process. If the addendum is completed prior to the comprehensive assessment, the hospice may not have a complete patient profile, which could potentially result in the hospice incorrectly anticipating the extent of covered and non-covered services and lead to an inaccurate election statement addendum. Hospice providers are only able to discern what items, services, and drugs they will not cover once they have a beneficiary's comprehensive assessment. We are proposing to allow the hospice to furnish the addendum within 5 days from the date of a beneficiary or representative request, if the request is within 5 days from the date of a hospice election. For example, if the patient elects hospice on December 1st and requests the addendum on December 3rd, the hospice would have until December 8th to furnish the addendum.

Additionally, hospices have noted that there is not a timeframe in regulations regarding the patient signature on the addendum. Section 418.24(c)(9) requires the beneficiary's signature (or his/her representative's signature) as well as the date the document was signed. We noted in the FY 2021 Hospice Wage Index & Payment Rate Update final rule that because the beneficiary signature is an acknowledgement of receipt of the addendum, this means the beneficiary would sign the addendum when the hospice provides it, in writing, to the beneficiary or representative (85 FR 47092). Additionally, obtaining the required signatures on the election statement has been a longstanding regulatory requirement. Therefore, we expect that hospices already have processes and procedures in place to ensure that required signatures are obtained, either from the beneficiary, or from the representative in the event the beneficiary is unable to sign. We anticipate that hospices would use the same procedures for obtaining signatures on the addendum. However, we understand that some beneficiaries or representatives may request an emailed addendum or request more time to review the addendum before signing, in which case 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. This means the hospice may furnish the addendum within the required timeframe; however, the signature date may be beyond the required timeframe. Therefore, we propose to clarify in regulation that the ''date furnished'' must be within the required timeframe (that is, 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date. At § 418.24(c)(10), we propose that the hospice would include the ''date furnished'' in the patient's medical record and on the addendum itself.

In the FY 2021 Hospice Wage Index and Payment Rate Update final rule, we addressed a concern regarding a potential situation wherein the beneficiary or representative refuses to sign the addendum (85 FR 47088). We reiterated that the signature on the addendum is only acknowledgement of receipt and not a tacit agreement of its contents, and that we expect the hospice to inform the beneficiary of the purpose of the addendum and rationale for the signature. However, we recognized that there might be rare instances in which the beneficiary (or representative) refuses to sign the addendum. We noted that we would consider whether this issue would require future rulemaking. We have subsequently received this question from stakeholders post implementation, therefore, in this proposed rule, we are clarifying that if a patient or representative refuses to sign the addendum, 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 3 or 5 days of the beneficiary or representative request, depending on when such request was made), and noted in the chart and on the addendum itself.

Stakeholders again requested that CMS clarify whether a non-hospice provider is required to sign the addendum in the event that the non-hospice provider requests the addendum rather than the beneficiary or representative. Therefore, if only a non-hospice provider or Medicare contractor requests the addendum (and not the beneficiary or representative) we would not expect a signed copy in the patient's medical record. Hospices can develop processes (including how to document such requests from non-hospice providers and Medicare contractors) to address circumstances in which the non-hospice provider or Medicare contractor requests the addendum, and the beneficiary or representative does not. As such, we are proposing to clarify in regulation that if a non-hospice provider requests the addendum, rather than the beneficiary or representative, the non-hospice provider is not required to sign the addendum.

There may be instances in which the beneficiary or representative requests the addendum and the beneficiary dies, revokes, or is discharged prior to signing the addendum. While we stated in the FY 2020 Hospice Wage Index and Payment Rate Update final rule, that if the beneficiary requests the election statement addendum at the time of hospice election but dies within 5 days, the hospice would not be required to furnish the addendum as the requirement would be deemed as being met in this circumstance (84 FR 38521), this policy was not codified in regulation. Therefore, we are proposing conforming regulations text changes at § 418.24(c) to reflect this policy. Furthermore, we propose to clarify at § 418.24(d)(4) that if the patient revokes or is discharged within the required timeframe (3 or 5 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. Similarly, we are proposing to clarify at § 418.24(d)(5) that in the event that a beneficiary requests the addendum and the hospice furnishes the addendum within 3 or 5 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. We 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.

Finally, we are proposing conforming regulations text changes at § 418.24(c) in alignment with subregulatory guidance indicating that hospices have ''3 days,'' rather than ''72 hours'' to meet the requirement when a patient requests the addendum during the course of a hospice election. Hospices must furnish the addendum no later than 3 calendar days after a beneficiary's (or representative's) request during the course of a hospice election. 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. For example, if a beneficiary (or representative) requests the addendum on February 22nd, then the hospice will have until February 25th to furnish the addendum, regardless of what time the addendum was requested on February 22nd. The intent of this clarification is to better align with the requirement for furnishing an election statement addendum when the addendum is requested within 5 days of the date of election, which also uses ''days'' rather than ''hours''.

We are soliciting comments on these proposed clarifications and conforming regulation text changes.

E. Hospice Waivers Made Permanent Conditions of Participation

1. Background

In order to support provider and supplier communities due to the COVID–19 PHE, CMS has issued an unprecedented number of regulatory waivers under our statutory authority set forth at section 1135 of the Act. Under section 1135 of the Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the programs in the emergency area and time periods, and that providers who furnish such services in good faith, but who are unable to comply with one or more requirements as described under section 1135(b) of the Act, can be reimbursed and exempted from sanctions for violations of waived provisions (absent any determination of fraud or abuse). The intent of these waivers was to expand healthcare system capacity while continuing to maintain public and patient safety, and to hold harmless providers and suppliers unable to comply with existing regulations after a good faith effort.

While some of these waivers simply delay certain administrative deadlines, others directly affect the provision of patient care. The utilization and application of these waivers pushed us to consider whether permanent changes would be beneficial to patients, providers, and professionals. We identified selected waivers as appropriate candidates for formal regulatory changes. Those proposed changes and their respective histories and background information are discussed in detail in section II. E of this rule. We are also proposing regulatory

changes that are not directly related to PHE waivers but would clarify or align some policies that have been raised as concerns by stakeholders.

We are proposing the following revisions to the hospice Conditions of Participation (CoPs).

2. Hospice Aide Training and Evaluation—Using Pseudo-Patients

Hospice aides deliver a significant portion of direct care. Aides are usually trained by an employer, such as a hospice, home health agency (HHA) or nursing home and may already be certified as an aide prior to being hired. The competency of new aides must be evaluated by the hospice to ensure appropriate care can be provided by the aide. Aide competency evaluations should be conducted in a way that identifies and meets training needs of the aide as well as the patient's needs. These evaluations are a critical part of providing safe, quality care. In September of 2019, we published a final rule that allows the use of the pseudo-patient for conducting home health aide competency evaluations (''Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care'' (84 FR 51732)). The ability to use pseudo-patients during aide competency evaluations allows greater flexibility and may reduce burden on suppliers. We believe that hospices and their patients would also benefit from the ability to use pseudo-patients in aide training.

The current hospice aide competency standard regulations at § 418.76(c)(1) requires the aide to be evaluated by observing an aide's performance of the task with a patient. We propose to make similar changes to hospice aide competency standards to those already made with respect to HHAs (see § 484.80(c)) in our hospice regulations at § 418.76(c)(1)), which describes the process for conducting hospice aide competency evaluations, and propose to define both ''pseudo-patient'' and ''simulation'' at § 418.3. Thus, we are 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 homecare 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. This could increase the speed of performing competency testing and would allow new aides to begin serving patients more quickly while still protecting patient health and safety.

3. Hospice Aid Training and Evaluation—Targeting Correction of Deficiencies

We are also proposing to amend the requirement at § 418.76(h)(1)(iii) to specify that if an area of concern is verified by the hospice during the on-site 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 § 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. We believe when a deficient area(s) in the aide's care is assessed by the RN, there may be additional related competencies that may also lead to additional deficient practice areas. For example, if a patient's family informed the nurse that the patient almost fell when the aide was transferring the patient to a chair; the nurse could assess the aide's transferring technique to determine whether there was any improper form. The hospice must also conduct, and the hospice aide must complete, a competency evaluation related to the deficient and related transferring skills; such as transferring from bed to bedside commode or shower chair.

We request public comment on our proposed changes to allow for the use of the pseudo patient for conducting hospice aide competency testing, and the proposed change to allow the hospice to focus on the hospice aides' specific deficient skill(s) instead of completing a full competency evaluation. We especially welcome comments from hospices that implemented the use of pseudo-patients during the COVID–19 PHE and the additional proposal, that if an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation related to the deficient and related skill(s).

F. Proposals and Updates to the Hospice Quality Reporting Program

1. Background and Statutory Authority

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. Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA 2021 (Pub. L. 116–260) to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy will apply beginning with FY 2024 annual payment update (APU). Specifically, the Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

In addition, section 407(a)(2) of the CAA 2021 removes the prohibition on public disclosure of hospice surveys performed be a national accreditation agency in section 1865(b) of the Act, thus allowing the Secretary to disclose such accreditation surveys. In addition, section 407(a)(1) of the CAA 2021 adds new requirements in newly added section 1822(a)(2) to require each state and local survey agency, and each national accreditation body with an approved hospice accreditation program, to submit information respecting 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 the Secretary. This information will be published publicly on our website, such as Care Compare, in a manner that is easily accessible, readily understandable, and searchable no later than October 1, 2022. In addition, national accreditation bodies with approved hospice accreditation programs described above are required to use the same survey form used by state and local survey agencies, which is currently the Form CMS–2567, on or after October 1, 2021.

Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points through FY 2023 or 4 percentage points beginning in FY 2024 could result in the annual market basket update being less than zero percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the specified year. Any such reduction would not be cumulative nor be taken into account in computing the payment amount for subsequent FYs.

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form, manner, and at a time specified by the Secretary. Any measures selected by the Secretary must have been endorsed by the consensus-based entity which holds a performance measurement contract with the Secretary under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). However, section 1814(i)(5)(D)(ii) of the Act provides that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus-based entity, the Secretary may specify measures that are not endorsed, as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary. Section 1814(i)(5)(D)(iii) of the Act requires that the Secretary publish selected measures applicable with respect to FY 2014 no later than October 1, 2012.

In the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48234), and in compliance with section 1814(i)(5)(C) of the Act, we finalized the specific collection of data items that support the seven NQF-endorsed hospice measures described in Table 1. In addition, we finalized the Hospice Visits When Death is Imminent measure pair (HVWDII, Measure 1 and Measure 2) in the FY 2017 Hospice Wage Index and Payment Rate Update final rule, effective April 1, 2017. We refer the public to the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52144) for a detailed discussion.

The CAHPS Hospice Survey is a component of the CMS HQRP, which is used to collect data on the experiences of hospice patients and their family caregivers listed in their hospice records. Readers who want more information about the development of the survey, originally called the Hospice Experience of Care Survey, may refer to 79 FR 50452 and 78 FR 48261. National implementation of the CAHPS Hospice Survey commenced January 1, 2015, as stated in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452).

The CAHPS Hospice Survey measures received NQF endorsement on October 26, 2016 and was re-endorsed November 20, 2020 (NQF #2651). NQF endorsed six composite measures and two overall measures from the CAHPS Hospice Survey. Along with nine HIS-based quality measures, the CAHPS Hospice Survey measures are publicly reported on a designated CMS website that is currently Care Compare. Table 16 lists all quality measures currently adopted for the HQRP.

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TABLE 16: Quality Measures Currently Adopted for the Hospice Quality Reporting Program

Hospice Item Set		
NQF#	**Short name**	**Data collection began**
1617	Patients Treated with an Opioid who are Given a Bowel Regimen	October 1, 2014
1634	Pain Screening	October 1, 2014
1637	Pain Assessment	October 1, 2014
1638	Dyspnea Treatment	October 1, 2014
1639	Dyspnea Screening	October 1, 2014
1641	Treatment Preferences	October 1, 2014
1647	Beliefs/Values Addressed (if desired by the patient)	October 1, 2014
Not applicable	Hospice Visits when Death is Imminent (HVWDII) • *Measure 1* – Percent of patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last three days of life. • *Measure 2* - Measure 2: Percentage of patients receiving at least two visits from medical social workers,	April 1, 2017

	chaplains or spiritual counselors, licensed practical nurses or hospice aides in the last seven days of life.	
3235	Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen (NQF #1617) 2. Pain Screening (NQF#1634) 3. Pain Assessment (NQF #1637) 4. Dyspnea Treatment (NQF #1638) 5. Dyspnea Screening (NQF# 1639) 6. Treatment Preferences (NQF #1641) 7. Beliefs/Values Addressed (if desired by the patient) (NQF# 1647)	April 1, 2017
CAHPS Hospice Survey		
NQF#	**Short Name**	**Data collection began**
2651	CAHPS Hospice Survey – single measure • Communication with Family • Getting timely help • Treating patient with respect • Emotional and spiritual support • Help for pain and symptoms • Training family to care for the patient • Rating of this hospice • Willing to recommend this hospice	January 1, 2015

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The Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment at Admission measure (hereafter referred to as ''the HIS Comprehensive Assessment Measure'') underwent an off-cycle review by the NQF Palliative and End-of-Life Standing Committee and successfully received NQF endorsement in July 2017 (NQF 3235). The HIS Comprehensive Assessment Measure captures whether multiple key care processes were delivered upon patients' admissions to hospice in one measure as described in the Table 1. NQF 3235 does not require NQF's endorsements of the previous components to remain valid. Thus, if the components included in NQF 3235 do not individually maintain endorsement, the endorsement status of NQF 3235, as a single measure, will not change.

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), we finalized the policy for retention of HQRP measures adopted for previous payment determinations and seven factors for measure removal. In that same final rule, we discussed that we will issue public notice, through rulemaking, of measures under consideration for removal, suspension, or replacement. However, if there is reason to believe continued collection of a measure raises potential safety concerns, we will take immediate action to remove the measure from the HQRP and will not wait for the annual rulemaking cycle. Such measures will be promptly removed and we will immediately notify hospices and the public of our decision through the usual HQRP communication channels, including but not limited to listening sessions, email notification, Open Door Forums, HQRP Forums, and Web postings. In such instances, the removal of a measure will be formally announced in the next annual rulemaking cycle.

In the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622), we also adopted an eighth factor for removal of a measure. This factor aims to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. These costs are multifaceted and include the burden associated with complying with the program. The finalized reasons for removing quality measures are:

1. Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made;

2. Performance or improvement on a measure does not result in better patient outcomes;

3. A measure does not align with current clinical guidelines or practice;

4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available;

5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available;

6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available;

7. Collection or public reporting of a measure leads to negative unintended consequences; or

8. The costs associated with a measure outweighs the benefit of its continued use in the program.

On August 31, 2020, we added correcting language to the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Correcting Amendment (85 FR 53679) hereafter referred to as the FY 2021 HQRP Correcting Amendment. In this final rule, we made correcting amendments to 42 CFR 418.312 to correct technical errors

identified in the FY 2016 Hospice Wage Index and Payment Rate Update final rule. Specifically, the FY 2021 HQRP Correcting Amendment (85 FR 53679) adds paragraph (i) to § 418.312 to reflect our exemptions and extensions requirements, which were referenced in the preamble but inadvertently omitted from the regulations text. Thus, these exemptions or extensions can occur when a hospice encounters certain extraordinary circumstances.

As stated in the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622), we launched the Meaningful Measures initiative (which identifies high priority areas for quality measurement and improvement) to improve outcomes for patients, their families, and providers while also reducing burden on clinicians and providers. More information about the Meaningful Measures initiative can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.*

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we discussed our interest in developing quality measures using claims data, to expand data sources for quality measure development. While we acknowledged in that rule the limitations with using claims data as a source for measure development, there are several advantages to using claims data as part of a robust HQRP as discussed previously in the FY 2020 rule. We also discussed developing the Hospice Outcomes & Patient Evaluation (HOPE), a new patient assessment instrument that is planned to replace the HIS. See an update on HOPE development in section III.F.6, Update regarding the Hospice Outcomes & Patient Evaluation (HOPE) development.

We also discussed our interest in outcome quality measure development. Unlike process measures, outcome measures capture the results of care as experienced by patients, which can include aspects of a patient's health status and their experiences in the health system. The portfolio of quality measures in the HQRP will include outcome measures that reflect the results of care.

2. Proposal To Remove the Seven ''Hospice Item Set Process Measures'' From HQRP Beginning FY 2022

In the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48234), and in compliance with section 1814(i)(5)(C) of the Act, we finalized the specific collection of standardized data items, known as the HIS, that support the following NQF-endorsed measures:

- NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
- NQF #1634 Pain Screening
- NQF #1637 Pain Assessment
- NQF #1638 Dyspnea Treatment
- NQF #1639 Dyspnea Screening
- NQF #1641 Treatment Preferences
- NQF #1647 Beliefs/Values Addressed (if desired by the patient)

These measures were adopted to increase public awareness of key components of hospice care, such as pain and symptom management and non-clinical care needs. Consistent with our policy for measure retention and removal, finalized in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), we reviewed these measures against the factors for removal. Our analysis found that they meet factor 4: ''A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.'' We determined that the NQF #3235 HIS Comprehensive Assessment Measure, discussed in detail in the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52144), is a more broadly applicable measure and continues to provide, in a single measure, meaningful differences between hospices regarding overall quality in addressing the physical, psychosocial, and spiritual factors of hospice care upon admission.

The HIS Comprehensive Assessment Measure's ''all or none'' criterion requires hospices to perform all seven care processes in order to receive credit. In this way, it is different from an average-based composite measure and sets a higher bar for performance. This single measure differentiates hospices and holds them accountable for completing all seven process measures to ensure core services of the hospice comprehensive assessment are completed for all hospice patients. Therefore, the HIS Comprehensive Assessment Measure continues to encourage hospices to improve and maintain high performance in all seven processes simultaneously, rather than rely on its component measures to demonstrate quality hospice care in a way that may be hard to interpret for consumers. The individual measures show performance for only one process and do not demonstrate whether the hospice provides high-quality care overall, as an organization. For example, a hospice may perform extremely well assessing treatment preferences, but poorly on addressing pain. High-quality hospice care not only manages pain and symptoms of the terminal illness, but assesses non-clinical needs of the patient and family caregivers, which is a hallmark of patient-centered care. Since the HIS Comprehensive Assessment Measure captures all seven processes collectively, we believe that public display of the individual component measures are not necessary.

The interdisciplinary, holistic scope of the NQF #3235 HIS Comprehensive Assessment Measure aligns with the public's expectations for hospice care. In addition, the measure supports alignment across our programs and with other public and private initiatives. The seven individual components address care processes around hospice admission that are clinically recommended or required in the hospice CoPs. The Medicare Hospice CoPs require that hospice comprehensive assessments identify patients' physical, psychosocial, emotional, and spiritual needs and address them to promote the hospice patient's comfort throughout the end-of-life process. Furthermore, the person-centered, family, and caregiver perspective align with the domains identified by the CoPs and the National Consensus Project [22] as patients and their family caregivers also place value on physical symptom management and spiritual/psychosocial care as important factors at the end-of-life. The HIS Comprehensive Assessment Measure is a composite measure that serves to ensure all hospice patients receive a comprehensive assessment for both physical and psychosocial needs at admission.

In addition, MedPAC's Report to Congress: Medicare Payment Policy [23] over the past few years notes that the HIS Comprehensive Assessment Measure differentiates the hospice's overall ability to address care processes better than the seven individual HIS process measures. In this way, it provides consumers viewing data on Care Compare with a streamlined way to

[22] The National Consensus Project Guidelines expand on the eight domains of palliative care in the 3rd edition and include clinical and organizational strategies, screening and assessment elements, practice examples, tools and resources. The guidelines were developed by the National Consensus Project for Quality Palliative Care, comprising 16 national organizations with extensive expertise in and experience with palliative care and hospice, and were published by the National Coalition for Hospice and Palliative Care. Journal of Hospice & Palliative Nursing: December 2018—Volume 20—Issue 6—p 507.

[23] MedPAC. (2020). *Chapter 12: Hospice Services. http://medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.*

assess the extent to which a hospice follows care processes.

We are not proposing any revisions to the HIS Comprehensive Assessment Measure in this proposed rule because the single measure continues to provide value to patients, their families, and providers.

Because the HIS Comprehensive Assessment Measure is a more broadly applicable measure, we propose to remove the seven individual HIS process measures from the HQRP, no longer publicly reporting them as individual measures on Care Compare beginning with FY 2022. In addition, we are proposing to remove the ''7 measures that make up the HIS Comprehensive Assessment Measure'' section of Care Compare, which displays the seven HIS measures. We propose to make these changes removing the seven HIS process measures as individual measures from HQRP no earlier than May 2022.

Although this proposal removes the seven individual HIS process measures, it does not propose any changes to the requirement to submit the HIS admission assessment. Since the HIS Comprehensive Assessment Measure is a composite of the seven HIS process measures, the burden and requirement to report the HIS data remain unchanged in the time, manner, and form finalized in the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52144). Hospices which do not report HIS data used for the HIS Comprehensive Assessment Measure will not meet the requirements for compliance with the HQRP.

We are soliciting public comment on the proposal to remove the seven HIS process quality measures as individual measures from the HQRP no earlier than May 2022, and to continue including the seven HIS process measures in the confidential quality measure (QM) Reports which are available to hospices. The seven HIS process measures are also available by visiting the data catalogue at *https://data.cms.gov/provider-data/topics/hospice-care.* We are also seeking public comment on the technical correction to the regulation at § 418.312(b) effective October 1, 2021.

3. Proposal To Add a ''Claims-Based Index Measure'', the Hospice Care Index

We are proposing a new hospice quality measure, called the Hospice Care Index (HCI), which will provide more information to better reflect several processes of care during a hospice stay, and better empower patients and family caregivers to make informed health care decisions. The HCI is a single measure comprising ten indicators calculated from Medicare claims data. The index design of the HCI simultaneously monitors all ten indicators. Collectively these indicators represent different aspects of hospice service and thereby characterize hospices comprehensively, rather than on just a single care dimension. Therefore, the HCI composite yields a more reliable provider ranking.

The HCI indicators, through the composite, would add new information to HQRP that was either directly recommended for CMS to publicly report by Federal stakeholders [23] [24] or identified as areas for improvement during information gathering activities. Furthermore, each indicator represents either a domain of hospice care recommended by leading hospice and quality experts [25] for CMS to publicly report, or a requirement included in the hospice CoPs. The indicators required to calculate the single composite are discussed in the ''Specifications for the HCI Indicators Selected'' section below. These specifications list all the information required to calculate each indicator, including the numerator and denominator definitions, different thresholds for receiving credit toward the overall HCI score, and explanations for those thresholds. Indicators reflect practices or outcomes hospices should pursue, thereby awarding points based on the criterion. The HCI scoring example in Table 16 illustrates how points are awarded based on meeting the criterion of the indicator. For example, Gaps in Nursing Visits have a criterion of ''lower than the 90th percentile,'' and supports the hospice CoPs that require a member of the interdisciplinary team to ensure ongoing assessment of patient and caregiver needs and plan of care implementation. Other indicators, such as nurse visits on weekends or near death, have a criterion of ''higher than the 10th percentile,'' identifying hospice care delivery during the most vulnerable periods during a hospice stay.

Each indicator equally affects the single HCI score, reflecting the equal importance of each aspect of care delivered from admission to discharge. A hospice is awarded a point for meeting each criterion for each of the 10 indicators. The sum of the points earned from meeting the criterion of each indictor results in the hospice's HCI score, with 10 as the highest hospice score. The ten indicators, aggregated into a single HCI score, convey a broad overview of the quality of hospice care provision and validates well with CAHPS Willingness to Recommend and Rating of this Hospice.

The HCI will help to identify whether hospices have aggregate performance trends that indicate higher or lower quality of care relative to other hospices. Together with other measures already publicly reported in the HQRP, HCI scores will help patients and family caregivers better decide between hospice providers based on the factors that matter most to them. Additionally, creating a comprehensive quality measure capturing a variety of related care processes and outcomes in a single metric will provide consumers and providers an efficient way to assess the overall quality of hospice care, which can be used to meaningfully and easily compare hospice providers to make a better-informed health care decision.

The HCI will complement the existing HIS Comprehensive Measure and does not replace any existing reported measures. Both the HCI and the HIS Comprehensive Measure are composite measures in that they act as single measures that capture multiple areas of hospice care. Because the indicators comprising the HCI differ in data source from the HIS Comprehensive Measure, the HCI and the HIS Comprehensive Measure can together provide a meaningful and efficient way to inform patients and family caregivers, and support their selection of hospice care providers. As a claims-based measure, the HCI measure would not impose any new collection of information requirements. To learn more about the background of the HCI, please watch this video: *https://youtu.be/by68E9E2cZc*.

a. Measure Importance

The FY 2019 Hospice Wage Index and Payment Rate Update final rule (83 FR 38622) introduced the Meaningful Measure Initiative to hospice providers to identify high priority areas for quality measurement and improvement. The Meaningful Measure Initiative areas are intended to increase measure alignment across programs and other public and private initiatives. Additionally, the initiative points to high priority areas where there may be informational gaps in available quality measures, while helping guide our efforts to develop and implement quality measures to fill those gaps, and develop those concepts towards quality measures that meet standards for public reporting. The goal of HQRP quality measure development is to identify measures from a variety of data sources that provide a window into

[23] 2019: Vulnerabilities in Hospice Care (Office of the Inspector General).

[24] Report to Congress: Medicare Payment Policy (March 2019) MEDPAC.

[25] 2019: Vulnerabilities in Hospice Care (Office of the Inspector General).

hospice care throughout the dying process, fit well with the hospice business model, and meet the objectives of the Meaningful Measures initiative.

To that end, the HCI seeks to add value to the HQRP by filling informational gaps in aspects of hospice service not addressed by the current measure set. Consistent with the Meaningful Measure Initiative, we conducted a number of information gathering activities to identify informational gaps. Our information gathering activities included soliciting feedback from hospice stakeholders such as providers and family caregivers; seeking input from hospice and quality experts through a Technical Expert Panel (TEP); interviews with hospice quality experts; considering public comments received in response to previous solicitations on claims-based hospice quality initiatives; and a review of quality measurement recommendations offered by the OIG, MedPAC, and the peer-reviewed literature.

We found that hospices currently underutilize HQRP measures to inform their quality improvement, mainly because of gaps in relevant quality information within the HQRP measure set. In particular, the existing HQRP measure set, calculated using data collected from the HIS and the CAHPS Hospice survey, does not assess quality of hospice care during a hospice election (between admission and discharge). Moreover, the current measure set does not directly address the full range of hospice services or outcomes. Therefore, we have identified a need for a new quality measure to address this gap and reflect care delivery processes during the hospice stay using available data without increasing data collection burden.

Claims data are the best available data source for measuring care during the hospice stay and present an opportunity to bridge the quality measurement gap that currently exists between the HIS and CAHPS Hospice Survey. Medicare claims are administrative records of health care services provided and payments which Medicare (and beneficiaries as applicable) made for those services. Claims are a rich and comprehensive source about many care processes and aspects of health care utilization. As such, they are a valuable source of information that can be used to measure the quality of care provided to beneficiaries for several reasons:

- Claims data are readily-available and reduce provider burden for implementation, as opposed to data collection through patient assessments or surveys, which require additional effort from clinicians, patients, and family caregivers before they can be submitted and used by CMS.
- Claims data are collected based on care delivered, providing a more direct reflection of care delivery decisions and actions than patient assessments or surveys.
- Claims data are considered a reliable source of standardized data about the services provided, because providers must comply with Medicare payment and claims processing policy.

Currently, CMS does publicly report several pieces of information derived from hospice claims data in the HQRP on Care Compare, including (i) the levels of care the hospice provided, (ii) the primary diagnoses the hospice served, (iii) the sites of service hospices provided care, and (iv) the hospice's daily census.

In the FY2018 Hospice Wage Index & Payment Rate proposed rule (82 FR 20750), we solicited public comment on two high-priority claims-based measure concepts being considered at the time, one which looked at transitions from hospice and another which examined access to higher levels of hospice care. In response to this solicitation, CMS received public comments highlighting the potential limitations of a single concept claims-based measure. In particular, a single-concept claims-based measure may not adequately account for all relevant circumstances that might influence a hospice's performance. While external circumstances could justify a hospice's poor performance on a single claims-based indicator, it would be unlikely for external circumstances to impact multiple claims-based indicators considered simultaneously. Therefore, the results of a multi-indicator claims-based index, such as HCI, is more likely to differentiate hospices than a single claims-based indicator. Taking this public feedback into consideration, we designed the HCI and developed the specifications based on simulated reporting periods.

b. Specifications for the HCI Indicators Selected

The specifications for the ten indicators required to calculate the single HCI score are described in this section. These component indicators reflect various elements and outcomes of care provided between admission and discharge. The HCI uses information from all ten indicators to collectively represent a hospice's ability to address patients' needs, best practices hospices should observe, and/or care outcomes that matter to consumers. Each indicator is a key component of the HCI measure that we are proposing, and all ten are necessary to derive the HCI score. We use analytics, based on a variety of data files, to specify the indicators and measure. These data files include:

- Medicare fee-for-service (FFS) hospice claims with through dates on and between October 1, 2016 and September 30, 2019 to determine information such as hospice days by level of care, provision of visits, live discharges, hospice payments, and dates of hospice election.
- Medicare fee-for-service inpatient claims with through dates on and between January 1, 2016 and December 31, 2019 to determine dates of hospitalization.
- Medicare beneficiary summary file to determine dates of death.
- Provider of Services (POS) File to examine trends in the scores of the HCI and its indicators, including by decade by which the hospice was certified for Medicare, ownership status, facility type, census regions, and urban/rural status.
- CAHPS Hospice Survey to examine alignment between the survey outcomes and the HCI.

We acquired all claims data from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC). We obtained the hospice claims and the Medicare beneficiary summary file in May 2020, and the inpatient data in August 2020. We obtained the POS file data via: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services.* We obtained the Hospice-aggregate CAHPS Hospice Survey outcome data via: *https://data.cms.gov/provider-data.* We performed analyses using Stata/MP Version 16.1.

Table 17 indicates the number of hospice days, hospice claims, beneficiaries enrolled in hospices and hospices with at least one claim represented in each year of our analysis. Analysis for each year was based on the FY calendar. For example, FY 2019 covers claims with dates of services on or between October 1, 2018 and September 30, 2019. For these analyses, we exclude claims from hospices with 19 or fewer discharges [26] within a FY. The table reports the sample size before and after exclusion.[27]

[26] We count discharges as any claim with a discharge status code other than ''30'' (which is defined as ''Still Patient'')

[27] Another exclusion was made prior to reporting the numbers in Table B.1. We exclude all claims for a beneficiary if a beneficiary ever had two overlapping hospice days on separate claims. For FY 2019 this removes 5,212,319 hospice days that come from 218,420 claims and 33,009 beneficiaries.

TABLE 17: Sample Size for Analyses by Federal Fiscal Year (FY)

	FY 2018		FY 2019	
Excluding claims from hospices with <20 discharges	**Before Exclusion**	**After Exclusion**	**Before Exclusion**	**After Exclusion**
Number of hospice days represented	106,406,018	105,750,624	113,762,656	113,085,444
Number of claims	4,775,310	4,747,725	5,048,355	5,019,848
Number of beneficiaries represented	1,522,290	1,515,186	1,569,350	1,562,003
Number of hospices represented	4,623	4,004	4,796	4,155

The rest of this section presents the component indicators and their specifications. Although we describe each component indicator separately, the HCI is a composite that can only be calculated using all 10 indicators combined. We believe that, composed of this set of ten indicators, the HCI will strengthen the HQRP by comprehensively, reflecting hospices' performance across all ten indicators.

(1). Indicator One: Continuous Home Care (CHC) or General Inpatient (GIP) Provided

Medicare Hospice Conditions of Participation (CoPs) require hospices to be able to provide both CHC and GIP levels of care, if needed to manage more intense symptoms.[28] [29] However, a 2013 OIG report [30] found that 953 hospice programs did not provide any GIP level of care services, and it was unclear if dying patients at such hospices were receiving appropriate pain control or symptoms management (a similar concern exists for hospice services at the CHC level). To consider the provision of adequate services needed to manage patients' symptoms, the HCI measure includes an indicator for whether hospice programs provided any CHC or GIP service days. This indicator identifies hospices that provided at least one day of hospice care under the CHC or the GIP levels of care during the period examined. The provision of CHC and GIP is identified on hospice claims by the presence of revenue center codes 0652 (CHC) and 0656 (GIP).

The specifications for Indicator One, CHC or GIP services provided, are as follows:

- Numerator: The total number of CHC or GIP services days provided by the hospice within a reporting period.
- Denominator: The total number of hospice service days provided by the hospice at any level of care within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if they provided at least one CHC or GIP service day within a reporting period.

(2). Indicator Two: Gaps in Nursing Visits

The Medicare Hospice CoPs require a member of the interdisciplinary team to ensure ongoing assessment of patient and caregiver needs and plan of care implementation.[31] The OIG has found instances of infrequent visits by nurses to hospice patients.[32] To assess patients' receipt of adequate oversight, one HCI indicator examines hospices that have a high rate of patients who are not seen at least once a week by nursing staff.

This indicator 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. Days of hospice service are identified based on the presence of revenue center codes 0651 (routine home care (RHC)), 0652 (CHC), 0655 (inpatient respite care (IRC)), and 0656 (GIP) on hospice claims. We identify the dates billed for RHC, IRC, and GIP by examining the corresponding revenue center date (which identifies the first day in the sequence of days by level of care) and the revenue center units (which identify the number of days (including the first day) in the sequence of days by level of care). We identify the dates billed for CHC by examining the revenue center date.[33] We define a hospice stay by a sequence of consecutive days for a particular beneficiary that are billed under the hospice benefit. A gap of at least 1 day without hospice ends the sequence. For this indicator, we identified hospice stays that included 30 or more consecutive days of hospice. Once we identified those hospice stays, we examined the timing of the provision of nursing visits within those stays. We identified nursing visits if we observed any of the following criteria:

- The presence of revenue center code 055x (Skilled Nursing) on the hospice claim. The date of the visit is recorded in the corresponding revenue center date.
- The presence of revenue code 0652 (CHC) on the hospice claim. Days billed as CHC require more than half the hours provided be nursing hours.
- The presence of revenue code 0656 (GIP) on the hospice claim. We assume that days billed as GIP will include nursing visits. We make that assumption instead of looking at the visits directly because Medicare does not require hospices to record all visits on the claim for the GIP level of care.

Based on the above information, if within a hospice stay, we find eight or more consecutive days where no nursing visits are provided, no CHC is provided, and no GIP is provided, then we identify the hospice stay as having a gap in nursing visits greater than 7 days. This indicator helps the HCI to capture patients' receipt of adequate oversight through nurse visits and direct patient care, which is an important aspect of hospice care. For each hospice, we divide the number of stays with at least one gap of eight or more days without a nursing visit (for stays of 30 or more days) by the number of stays of 30 or more days. We only consider the days within the period being examined.

The specifications for Indicator Two, Gaps in Nursing Visits, are as follows:

[28] See Special coverage requirements, Title 42, Chapter IV, Subchapter B, Part 418, § 418.204. *https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_1204.*

[29] See Payment procedures for hospice care, Title 42, Chapter IV, Subchapter B, Part 418, § 418.302. *https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_1302.*

[30] Office of Inspector General. (2013). *Medicare Hospice: Use of General Inpatient Care. https://oig.hhs.gov/oei/reports/oei-02-10-00490.pdf.*

[31] See § 418.56 (*https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_156*) and § 418.76 (*https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_176*).

[32] Office of Inspector General. (2019). *Hospice Deficiencies Pose Risks to Medicare Beneficiaries. https://oig.hhs.gov/oei/reports/oei-02-17-00020.pdf?utm_source=summary-page&utm_medium=web&utm_campaign=OEI-02-17-00020-PDF.*

[33] Hospices bill each day of CHC on a separate line item on the hospice claim.

• Numerator: The number of elections with the hospice where the patient experienced at least one gap between nursing visits exceeding 7 days, excluding hospice elections where the patient elected hospice for less than 30 days within a reporting period.

• Denominator: The total number of elections with the hospice, excluding hospice elections where the patient elected hospice for less than 30 days within a reporting period.

• Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for gaps in nursing visits greater than 7 days falls below the 90th percentile ranking among hospices nationally.

(3). Indicator Three: Early Live Discharges

Prior work has identified various concerning patterns of live discharge from hospice. High rates of live discharge suggest concerns in hospices' care processes, their advance care planning to prevent hospitalizations, or their discharge processes.[34] As MedPAC noted,[35] ''Hospice providers are expected to have some rate of live discharges because some patients change their mind about using the hospice benefit and dis-enroll from hospice or their condition improves and they no longer meet the hospice eligibility criteria. However, providers with substantially higher percent of live discharge than their peers could signal a potential concern with quality of care or program integrity. An unusually high rate of live discharges could indicate that a hospice provider is not meeting the needs of patients and families or is admitting patients who do not meet the eligibility criteria.''

Our live discharge indicators included in the HCI, like MedPAC's, comprise discharges for all reasons. They include instances where the patient was no longer found terminally ill and revocations due to the patient's choice. MedPAC explains their rationale for including all discharge as follows:[36]

''Some stakeholders argue that live discharges initiated by the beneficiary—such as when the beneficiary revokes his or her hospice enrollment—should not be included in a live-discharge measure because, some stakeholders assert, these discharges reflect beneficiary preferences and are not in the hospice's control. Because beneficiaries may choose to revoke hospice for a variety of reasons, which in some cases are related to the hospice provider's business practices or quality of care, we include revocations in our analysis.''

This indicator 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. Live discharges occur when the patient discharge status code on a hospice claim *does not* equal a code from the following list: ''30'', ''40'', ''41'', ''42'', ''50'', ''51''. We measure whether a live discharge occurs during the first 7 days of hospice by looking at a patient's lifetime length of stay in hospice.[37] For each hospice, we divide the number of live discharges in the first 7 days of hospice by the number of live discharges. Live discharges are assigned to a particular reporting period based on the date of the live discharge (which corresponds to the through date on the claim indicating the live discharge).

The specifications for Indicator Three, Early Live Discharges, are as follows:

• Numerator: The total number of live discharges from the hospice occurring within the first 7 days of hospice within a reporting period.

• Denominator: The total number of all live discharge from the hospice within a reporting period.

• Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual percentage of live discharges on or before the seventh day of hospice falls below the 90th percentile ranking among hospices nationally.

(4). Indicator Four: Late Live Discharges

The rate of live discharge that occurred 180 days or more after hospice enrollment identifies another potentially concerning pattern of live discharge from hospice. Both indicator three and indicator four of the HCI recognize concerning patterns of live discharge impacting patient experience and quality of care. MedPAC, in descriptive analyses of hospices exceeding the Medicare annual payment cap, noted that ''if some hospices have rates of discharging patients alive that are substantially higher than most other hospices it raises concerns that some hospices may be pursuing business models that seek out patients likely to have long stays who may not meet the hospice eligibility criteria''.[38] Because of quality implications for hospices who pursue such business models, the live discharge after long hospice enrollments was included in the index.

This indicator 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 occur when the patient discharge status code *does not* equal a value from the following list: ''30'', ''40'', ''41'', ''42'', ''50'', ''51''. We measure whether a live discharge occurs on or after the 180th day of hospice by looking at a patient's lifetime length of stay in hospice. For each hospice, we divide the number of live discharges that occur on or after the 180th day of hospice by the number of live discharges. Live discharges are assigned to a particular reporting period based on the date of the live discharge (which corresponds to the through date on the claim).

The specifications for Indicator Four, Late Live Discharges, are as follows:

• Numerator: The total number of live discharges from the hospice occurring on or after 180 days of enrollment in hospice within a reporting period.

• Denominator: The total number of all live discharge from the hospice within a reporting period.

• Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for live discharges on or after the 180th day of hospice falls below the 90th percentile ranking among hospices nationally.

(5). Indicator Five: Burdensome Transitions (Type 1)—Live Discharges From Hospice Followed by Hospitalization and Subsequent Hospice Readmission

The Type 1 burdensome transitions reflects hospice live discharge with a hospital admission within 2 days of hospice discharge, and then hospice readmission within 2 days of hospital discharge. This pattern of transitions may lead to fragmented care and may be associated with concerning care processes. For example, Type 1 burdensome transitions may arise from a deficiency in advance care planning to prevent hospitalizations or a discharge process that does not appropriately identify a hospice patient whose conditions are stabilized prior to discharge.[39]

[34] Teno J.M., Bowman, J., Plotzke, M., Gozalo, P.L., Christian, T., Miller, S.C., Williams, C., & Mor, V. (2015). Characteristics of hospice programs with problematic live discharges. Journal of Pain and Symptom Management, 50, 548–552. doi: 10.1016/j.jpainsymman.2015.05.001.

[35] MedPAC. (2020). *Chapter 12: Hospice Services. http://medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.*

[36] MedPAC. (2020). *Chapter 12: Hospice Services. http://medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.*

[37] That is, we are measuring the first seven days of hospice over a patient's lifetime and potentially across multiple hospice elections and fiscal years.

[38] MedPAC. (2020). *Chapter 12: Hospice Services. http://medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.*

[39] For example, see: Teno J.M., Bowman, J., Plotzke, M., Gozalo, P.L., Christian, T., Miller, S.C.,

This indicator identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that are followed by a hospitalization (within 2 days of hospice discharge) and then followed by a hospice readmission (within 2 days of hospitalization) during the FY examined. Live discharges occur when the patient discharge status code *does not* equal a value from the following list: ''30'', ''40'', ''41'', ''42'', ''50'', ''51''. Hospitalizations are found by looking at all fee-for-service Medicare inpatient claims. Overlapping inpatient claims were combined to determine the full length of a hospitalization (looking at the earliest from date and latest through date from a series of overlapping inpatient claims for a beneficiary). In order to be counted, the ''from'' date of the hospitalization had to occur no more than 2 days after the date of hospice live discharge.[40] From there, we found all beneficiaries that ended their hospitalization and were readmitted back to hospice no more than 2 days after the last date of the hospitalization. To calculate the percentage, for each hospice we divided the number of live discharges that are followed by a hospitalization (within 2 days of hospice discharge) and then followed by a hospice readmission (within 2 days of hospitalization) in a given reporting period by the number of live discharges in that same period.

The specifications for Indicator Five, Burdensome Transitions Type 1, are as follows:

- Numerator: The total number of live discharges from the hospice followed by hospital admission within 2 days, then hospice readmission within 2 days of hospital discharge within a reporting period.
- Denominator: The total number of all live discharge from the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for Type 1 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

(6). Indicator Six: Burdensome Transitions (Type 2)—Live Discharges From Hospice Followed by Hospitalization With the Patient Dying in the Hospital

Death in a hospital following live discharge in another concerning pattern in hospice use. Thus, we believe that indicators five and indicator six of the HCI are necessary to differentiate concerning behaviors affecting patient care. This indicator reflects hospice live discharge followed by hospitalization within 2 days with the patient dying in the hospital, referred to as Type 2 burdensome transitions. This pattern of transitions may be associated with a discharge process that does not appropriately assess the stability of a hospice patient's conditions prior to live discharge.[41]

This indicator 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. Live discharges occur when the patient discharge status code *does not* equal a value from the following list: ''30'', ''40'', ''41'', ''42'', ''50'', ''51''. Hospitalizations are found by looking at all inpatient claims. Overlapping inpatient claims were combined to determine a full length of a hospitalization (looking at the earliest from date and latest through date from a series of overlapping inpatient claims). To be counted, the ''from'' date of the hospitalization had to occur no more than 2 days after the date of hospice live discharge. From there, we identified all beneficiaries whose date of death is listed as occurring during the dates of the hospitalization. To calculate the percentage, for each hospice we divided the number of live discharges that are followed by a hospitalization (within 2 days of hospice discharge) and then the patient dies in the hospital in a given FY by the number of live discharges in that same reporting period.

The specifications for Indicator Six, Burdensome Transitions Type 2, are as follows:

- Numerator: The total number of live discharges from the hospice followed by a hospitalization within 2 days of live discharge with death in the hospital within a reporting year.
- Denominator: The total number of all live discharge from the hospice within a reporting year.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for Type 2 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

(7). Indicator Seven: Per-Beneficiary Medicare Spending

Estimates of per-beneficiary spending are endorsed by NQF (#2158)[42] and publicly reported by CMS for other care settings. Because the Medicare hospice benefit pays a per diem rate, an important determinant of per-beneficiary spending is the length of election. MedPAC reported that nearly half of Medicare hospice expenditures are for patients that have had at least 180 or more days on hospice, and expressed a concern that some programs do not appropriately discharge patients whose medical condition makes them no longer eligible for hospice services, or, that that hospices selectively enroll patients with non-cancer diagnoses and longer predicted lengths of stay in hospice.[43] The other determinant of per-beneficiary spending is the level of care at which services are billed. In a 2016 report, the OIG has expressed concern at the potentially inappropriate billing of GIP care.[44] For these reasons the HCI includes one indicator for per-beneficiary spending; lower rates of per beneficiary spending may identify hospices that provide efficient care at a lower cost to Medicare.

This indicator identifies whether a hospice is below the 90th percentile in terms of the average Medicare hospice payments per beneficiary. Hospice payments per beneficiary are determined by summing together all payments on hospice claims for a particular reporting year for a particular hospice. The number of beneficiaries a hospice serves in a particular year is determined by counting the number of unique beneficiaries on all hospice claims in the same period for a particular hospice. Medicare spending per beneficiary is then calculated by dividing the total payments by the total number of unique beneficiaries.

The specifications for Indicator Seven, Per-Beneficiary Medicare Spending, are as follows:

Williams, C., & Mor, V. (2015). Characteristics of hospice programs with problematic live discharges. Journal of Pain and Symptom Management, 50, 548–552. doi: 10.1016/j.jpainsymman.2015.05.001.

[40] For example, if the hospice discharge occurred on a Sunday, the hospitalization had to occur on Sunday, Monday, or Tuesday to be counted.

[41] For example, see: Teno J.M., Bowman, J., Plotzke, M., Gozalo, P.L., Christian, T., Miller, S.C., Williams, C., & Mor, V. (2015). Characteristics of hospice programs with problematic live discharges. Journal of Pain and Symptom Management, 50, 548–552. doi: 10.1016/j.jpainsymman.2015.05.001.

[42] National Quality Forum. (2013). *#2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB). https://www.qualityforum.org/Projects/c-d/Cost_and_Resource_Project/2158.aspx.*

[43] MedPAC. (2020). *Chapter 12: Hospice Services. http://medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.*

[44] Office of Inspector General. (2016). *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care. https://oig.hhs.gov/oei/reports/oei-02-10-00491.pdf.*

• Numerator: Total Medicare hospice payments received by a hospice within a reporting period.

• Denominator: Total number of beneficiaries electing hospice with the hospice within a reporting period.

• Index Earned Point Criterion: Hospices earn a point towards the HCI if their average Medicare spending per beneficiary falls below the 90th percentile ranking among hospices nationally.

(8). Indicator Eight: Nurse Care Minutes per Routine Home Care (RHC) Day

Medicare Hospice CoPs require a member of the interdisciplinary team to ensure ongoing assessment of patient and caregiver needs.[45] Such assessment is necessary to ensure the successful preparation, implementation, and refinements for the plan of care. Hospices must also ensure that patients and caregivers receive education and training as appropriate to their responsibilities for the care and services identified in the plan of care. To assess adequate oversight, the HCI includes this indicator assessing the average number of skilled nursing minutes per day during RHC days to differentiate hospices that are providing assessment throughout the hospice stay.

This indicator 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. We identify RHC days by the presence of revenue code 0651 on the hospice claim. We identify the dates of RHC service by the corresponding revenue center date (which identifies the first day of RHC) and the revenue center units (which identifies the number of days of RHC (including the first day of RHC)). We identify nursing visits by the presence of revenue code 055x (Skilled Nursing) on the claim. We count skilled nursing visits where the corresponding revenue center date overlaps with one of the days of RHC previously identified. We then count the minutes of skilled nursing visits by taking the corresponding revenue center units (that is, one unit is 15 minutes) and multiplying by 15. For each hospice, we sum together all skilled nursing minutes provided on RHC days and divide by the sum of RHC days.

The specifications for Indicator Eight, Nurse Care Minutes per RHC Day, are as follows:

• Numerator: Total skilled nursing minutes provided by a hospice on all RHC service days within a reporting period.

• Denominator: The total number of RHC days provided by a hospice within a reporting period.

• Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for Nursing Minutes per RHC day falls above the 10th percentile ranking among hospices nationally.

(9). Indicator Nine: Skilled Nursing Minutes on Weekends

Our regulations at § 418.100(c)(2) require that ''[n]ursing services, physician services, and drugs and biologicals . . . be made routinely available on a 24-hour basis seven days a week''.[46] Ongoing assessment of patient and caregiver needs and plan of care implementation are necessary for adequate hospice care oversight. Fewer observed hospice services on weekends (relative to that provided on weekdays) is not itself an indication of a lack of access. In fact, on weekends, patients' caregivers are more likely to be around and could prefer privacy from hospice staff. However, patterns of variation across providers could signal less service provider availability and access for patients on weekends. Thus, the HCI includes this indicator to further differentiate whether care is available to patients on weekends. To assess hospice service availability, this indicator includes minutes of care provided by skilled nurses on weekend RHC days.

This indicator 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. We identify RHC days by the presence of revenue code 0651 on the hospice claim. We identify the dates of RHC service by the corresponding revenue center date (which identifies the first day of RHC) and the revenue center units (which identifies the number of days of RHC (including the first day of RHC)). We identify nursing visits by the presence of revenue code 055x (Skilled Nursing) on the claim. We count skilled nursing visits where the corresponding revenue center date overlaps with one of the days of RHC previously identified. We then count the minutes of skilled nursing visits by taking the corresponding revenue center units and multiplying by 15. For each hospice, we sum together all skilled nursing minutes provided on RHC days that occur on a Saturday or Sunday and divide by the sum of all skilled nursing minutes provided on all RHC days.

The specifications for Indicator Nine, Skilled Nursing Minutes on Weekends, are as follows:

• Numerator: Total sum of minutes provided by the hospice during skilled nursing visits during RHC services days occurring on Saturdays or Sunday within a reporting period.

• Denominator: Total skilled nursing minutes provided by the hospice during RHC service days within a reporting period.

• Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for percentage of skilled nursing minutes provided during the weekend is above the 10th percentile ranking among hospices nationally.

(10). Indicator Ten: Visits Near Death

The end of life is typically the period in the terminal illness trajectory with the highest symptom burden. Particularly during the last few days before death, patients (and caregivers) experience many physical and emotional symptoms, necessitating close care and attention from the integrated hospice team and drawing increasingly on hospice team resources.[47] [48] [49] Physical symptoms of actively dying can often be identified within three days of death in some patients.[50]

This indicator 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 3 days of life. For this indicator, we first

[45] See Condition of participation: Interdisciplinary group, care planning, and coordination of services, Title 42, Chapter IV, Subchapter B, Part 418, § 418.56 (*https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_156*) and Condition of participation: Hospice aide and homemaker services, Title 42, Chapter IV, Subchapter B, Part 418, § 418.76 (*https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_176*).

[46] See § 418.100 (*https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_1100*).

[47] de la Cruz, M., et al. (2015). Delirium, agitation, and symptom distress within the final seven days of life among cancer patients receiving hospice care. Palliative & Supportive Care, 13(2): 211–216. doi: 10.1017/S1478951513001144.

[48] Dellon, E.P., et al. (2010). Family caregiver perspectives on symptoms and treatments for patients dying from complications of cystic fibrosis. Journal of Pain & Symptom Management, 40(6): 829–837. doi: 10.1016/j.jpainsymman.2010.03.024.

[49] Kehl, K.A., et al. (2013). A systematic review of the prevalence of signs of impending death and symptoms in the last 2 weeks of life. American Journal of Hospice & Palliative Care, 30(6): 601–616. doi: 10.1177/1049909112468222.

[50] Hui D et al. (2014). Clinical Signs of Impending Death in Cancer Patients. The Oncologist. 19(6):681–687. doi:10.1634/theoncologist.2013–0457.

determine if a beneficiary was in hospice for at least 1 day during their last 3 days of life by comparing days of hospice enrollment from hospice claims to their date of death. We identify nursing visits and medical social service visits by the presence of revenue code 055x (Skilled Nursing) and 056x (Medical Social Services) on the claim. We identify the dates of those visits by the revenue center date for those revenue codes.

Additionally, we assume that days billed as GIP (revenue code 0656) will include nursing visits. We make that assumption instead of looking at the visits directly because Medicare does not require hospices to record all visits on the claim for the GIP level of care. For each hospice, we divide the number of beneficiaries with a nursing or medical social service visits on a hospice claim during the last 3 days of life by the number of beneficiaries with at least 1 day of hospice during the last 3 days of life.

The specifications for Indicator Ten, Visits Near Death, are as follows:

- Numerator: The number of decedent beneficiaries receiving a visit by a skilled nurse or social worker staff for the hospice in the last 3 days of the beneficiary's life within a reporting period.
- Denominator: The number of decedent beneficiaries served by the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for percentage of decedents receiving a visit by a skilled nurse or social worked in the last 3 days of life falls above the 10th percentile ranking among hospices nationally.

(11). Hospice Care Index Scoring Example

As discussed during the NQF's January 2021 MAP meeting, the HCI summarizes information from ten indicators with each indicator representing key components of the hospice care recognizing care delivery and processes. Hospices receive a single HCI score, which reflects the information from all ten indicators. Specifically, a hospice's HCI score is based on its collective performance on the ten performance indicators detailed above, all of which must be included to calculate the score and meaningfully distinguish between hospices' relative performance. The HCI's component indicators are assigned a criterion determined by statistical analysis of an individual hospice's indicator score relative to national hospice performance. Table 18 illustrates how a hypothetical hospice's score is determined across all ten indicators, and how the ten indicators' scores determine the overall HCI score.

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TABLE 18: Hospice Care Index Indicator Scoring Example

Name (Hospice Score Units)	Numerator	Denominator	Hospice Observed Score	National Average Score	Percentile Rank Among Hospices Nationally	Index Earned Point Criteria	Points Earned?	Points Awarded
Provided CHC/GIP (% days)	48	3,904	1.2%	0.9%	83	Hospice Score Above 0%	Yes	+1
Gaps in nursing visits (% elections)	12	104	11.5%	5.9%	92	Below 90 Percentile Rank	No	0
Early live discharges (% live discharges)	3	27	11.1%	7.7%	75	Below 90 Percentile Rank	Yes	+1
Late live discharges (% live discharges)	14	27	51.9%	37.3%	84	Below 90 Percentile Rank	Yes	+1
Burdensome transitions, Type 1 (% live discharges)	4	27	14.8%	8.7%	77	Below 90 Percentile Rank	Yes	+1
Burdensome transitions, Type 2 (% live discharges)	0	27	0.0%	2.7%	1	Below 90 Percentile Rank	Yes	+1
Per-beneficiary Medicare spending (U.S. dollars $)	$2,322,657	256	$9,073	$12,959	22	Below 90 Percentile Rank	Yes	+1
Nurse care minutes per routine home care day (minutes)	44,100	6,985	6.3	16.0	2	Above 10 Percentile Rank	No	0
Skilled nursing minutes on weekends (% minutes)	9,090	157,230	5.8%	9.4%	17	Above 10 Percentile Rank	Yes	+1
Visits near death (% decedents)	147	151	97.4%	94.5%	46	Above 10 Percentile Rank	Yes	+1
						Hospice Care Index Total Score =		**8**

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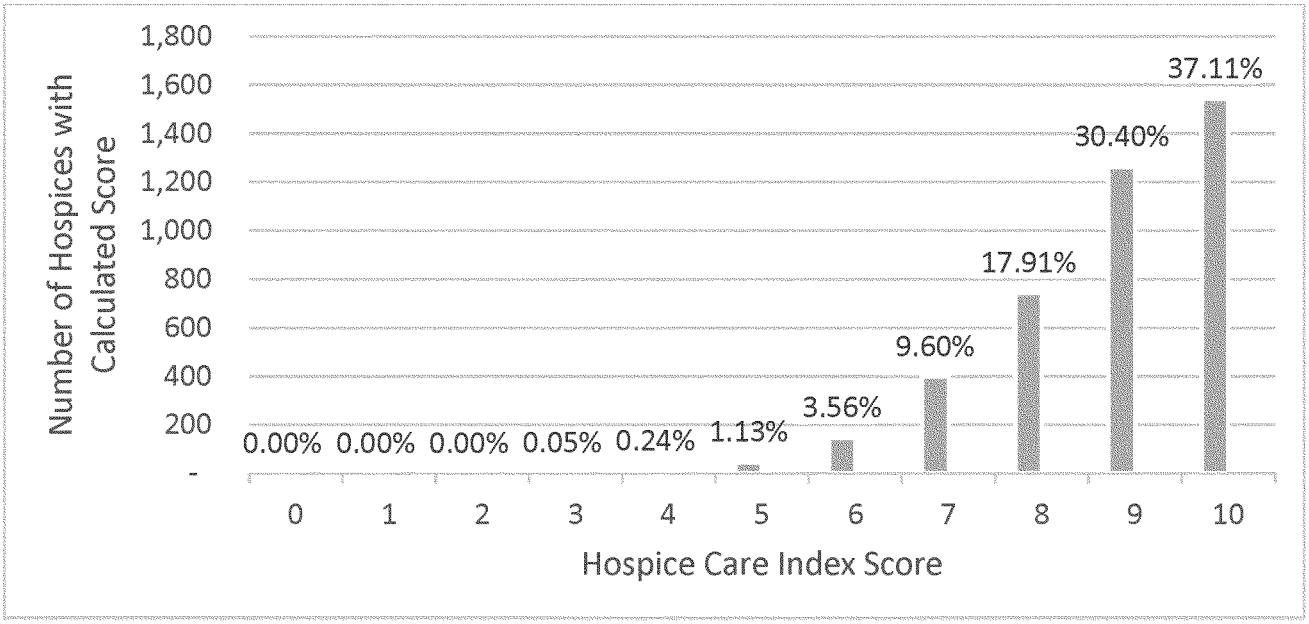
c. Measure Reportability, Variability, and Validity

As part of developing the HCI, we conducted reportability, variability, and validity testing using claims data from FY 2019. Reportability analyses found a high proportion of hospices (over 85 percent) that would yield reportable measure scores over 1 year (for more on reportability analysis, see section (2) Update on Use of Q4 2019 Data and Data Freeze for Refreshes in 2021.). Variability analyses confirmed that HCI demonstrates sufficient ability to differentiate hospices. Hospices' scores on the HCI can range from zero to ten. During measure testing, we observed that hospices achieved scores between three and ten. In testing, 37.1 percent of hospices scored ten out of ten, 30.4 percent scored nine out of ten, 17.9 percent scored eight out of ten, 9.6 percent scored seven out of ten, and 5.0 percent scored six or lower, as shown in Figure 6.

Figure 6: Distribution of Hospice Care Index Scores, Federal Fiscal Year 2019



Source: 100% Medicare hospice claims, Federal Fiscal Year 2019.

Validity analyses showed that hospices' HCI scores align with family caregivers' perceptions of hospice quality, as measured by CAHPS Hospice survey responses (NQF endorsed quality measure #2651). Hospices with higher HCI scores generally achieve better caregiver ratings as measured by CAHPS Hospice scores, and hospices with lower HCI scores generally achieve poorer CAHPS Hospice scores. As measured by Pearson's correlation coefficients, the correlation between the CAHPS hospice overall rating and the HCI is +0.0675, and the correlation between the CAHPS hospice recommendation outcome and the HCI score is +0.0916. As such, HCI scores are consistent with CAHPS Hospice caregiver ratings, supporting the index as a valid measurement of hospice care.

We also conducted a stability analysis by comparing index scores calculated for the same hospice using claims from Federal FY 2017 and 2019. The analysis found that 82.8 percent of providers' scores changed by, at most, one point over the 2 years. These results serve as evidence of the measure's reliability by indicating that a hospice's HCI scores would not normally fluctuate a great deal from one year to the next.

d. Stakeholder Support

A TEP convened by our measure development contractor, in April 2020, provided input on this measure concept. Additionally, during the summer of 2020, CMS convened five listening sessions with national hospice provider organizations to discuss the HCI concept with the goals of engaging stakeholders and receiving feedback early in the measure's development. In October 2020, our contractor, Abt Associates, convened a workgroup of family caregivers whose family members have received hospice care to provide input on this measure concept from the family and caregiver perspective. Finally, the NQF Measures Application Partnership (MAP) met on January 11, 2021 and provided input to CMS. The MAP conditionally supports the HCI for rulemaking contingent on NQF endorsement. The ''2020–2021 MAP 2020 Final Recommendations'' can be found at: *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=94893.*

Stakeholders were generally supportive of a quality measure based on multiple indicators using claims data for public reporting. Several hospice providers expressed support for the measure's ability to demonstrate greater variation in hospice performance than the component indicators taken individually. Hospice caregivers also welcomed the addition of new quality measures to HQRP to better differentiate between hospices. In particular, family caregivers stated that there might be a need for several HCI indicators, such as nursing availability on weekends and average Medicare per-beneficiary spending, to be included on Care Compare as additional information.

Some stakeholders raised concerns that claims data may not adequately express the quality of care provided, and may be better suited as an indicator for program integrity or compliance issues. Hospice providers suggested that claims may lack sufficient information to adequately reflect individual patient needs or the full array of hospice

practices. In particular, claims do not fully capture patients' clinical conditions, patient and caregiver preferences, or hospice activities such as telehealth, chaplain visits, and specialized services such as massage or music therapy. After much consideration of the input received, we believe the benefits of proposing adoption of the HCI outweigh its limitations. The HCI would not be intended to account for all potentially valuable aspects of hospice care, nor would it be expected to entirely close the information gaps presently found in the HQRP. Rather, the HCI would serve as a useful measure to add value to the HQRP by providing more information to patients and family caregivers and better empowering them to make informed health care decisions. We view the HCI as an opportunity to add value to the HQRP, augmenting the current measure set with an index of indicators compiled from currently available claims data. This will provide new and useful information to patients and family caregivers without further burden to them, or to providers.

Stakeholders also suggested several valuable exploratory analyses, improvements for the indicators presented, and ideas for eventual public display for CMS to consider. We further refined the HCI based on this feedback, focusing on those indicators with the strongest consistency with CAHPS Hospice scores and/or which quality experts have identified as salient issues for measurement and observation. We also revised and refined how the HCI will be publicly displayed on Care Compare in response to family caregiver input.

e. Form, Manner and Timing of Data Collection and Submission

The data source for this HCI measure will be Medicare claims data that are already collected and submitted to CMS. We propose to begin reporting this measure using existing data items no earlier than May 2022. For more details, see section (3). Proposal to Publicly Report the Hospice Care Index and Hospice Visits in the Last Days of Life Claims-based Measures.

In addition, to help hospices understand the HCI and their hospice's performance, we will revise the confidential QM report to include claims-based measure scores, including agency and national rates through the Certification and Survey Provider Enhanced Reports (CASPER) or replacement system. The QM report will also include results of the individual indicators used to calculate the single HCI score, and provide details on the indicators and HCI overall score to support hospices in interpreting the information. The HCI indicators will be available by visiting the Provider Data Catalog at *https://data.cms.gov/provider-data/topics/hospice-care.*

We are soliciting public comment on the proposal to add the composite HCI measure to the HQRP starting in FY 2022. We are also soliciting comments on the proposal to add the HCI to the program for public reporting beginning no earlier than May 2022.

4. Update on the Hospice Visits in the Last Days of Life (HVLDL) and Hospice Item Set V3.00

On August 13, 2020, we sought public comment in an information collection request to remove Section O ''Service Utilization'' (hereafter referred to as Section O) of the HIS discharge assessment. Removal of Section O is the sole change from HIS V2.01 and in effect eliminate the HVWDII quality measure pair. In Paperwork Reduction Act package (PRA), CMS–10390 (OMB control number: 0938–1153), we also proposed to replace the HVWDII measure pair with the HVLDL. This means that we will no longer report HVWDII with patient discharges and will start publicly reporting HVLDL no earlier than May 2022. The Office of Management and Budget (OMB) approved the collection of information to remove Section O of the HIS expiring on February 29, 2024, (OMB Control Number: 0938–1153, CMS–10390). We direct the public to review the PRA at *https://www.cms.gov/regulations-and-guidancelegislation paperworkreductionactof1995pra-listing/cms-10390* and HVWDII report at *https://www.cms.gov/files/document/hqrphospice-visits-when-death-imminent-testing-re-specification-reportoctober-2020.pdf.* As a claims-based measure, the HVLDL measure would not impose any new collection of information requirements.

The HVLDL measure, as a replacement, will continue to fill an important area in hospice care previously filled by the HVWDII measure pair. We discussed the analysis with a TEP convened by our measure development contractor in November 2019 and with the MAP, hosted by the NQF in December 2019 [51] for inclusion in the HQRP. During these meetings, the discussions reflecting on the analysis generally supported the replacement of HVWDII with a claims-based HVLDL measure. The November 2019 TEP report can be found in the downloads section at Hospice QRP Provider Engagement Opportunities and final recommendations and presentation of the HVLDL measure before NQF's MAP can be found at Quality Forum—Post-Acute Care, *https://www.qualityforum.org/Publications/2020/02/MAP_2020_Considerations_for_Implementing_Measures_Final_Report_-_PAC_LTC.aspx.*

OMB approved the proposal to replace the HVWDII measure with the HVLDL measure and remove Section O from the discharge assessment on February 16, 2021. The HIS V3.00 became effective on February 16, 2021 and expires on February 29, 2024; OMB control number 0938–1153.

5. Proposal To Revise § 418.312(b) Submission of Hospice Quality Reporting Program Data

To address the inclusion of administrative data, such as Medicare claims used for hospice claims-based measures like the HVLDL and HCI in the HQRP and correct technical errors identified in the FY 2016 and 2019 Hospice Wage Index and Payment Rate Update final rules, we propose to revise the regulation at § 418.312(b) by adding paragraphs (b)(1) through (3). As proposed, paragraph (b)(1) would now include the existing language on the standardized set of admission and discharge items. Paragraph (b)(2) would require collection of Administrative Data, such as Medicare claims data, used for hospice quality measures to capture services throughout the hospice stay. And these data automatically meet the HQRP requirements for § 418.306(b)(2).

Paragraph (b)(3) would be a technical correction to address errors identified in the FY 2016 and FY 2019 Hospice Wage Index and Payment Rate Update final rules, (80 FR 47186 and 83 FR 38636). In the FY 2016 Hospice final rule (80 FR 47186) adopted seven factors for measure removal, and in the FY 2019 Hospice final rule (83 FR 38636) adopted the eighth factor for measure removal. In those final rules, we referenced the measure removal factors in the preamble but inadvertently omitted them from the regulations text. Thus, these measure removal factors identify how measures are removed from the HQRP. Section 418.312(b)(3) would include the eight measure removal factors as follows:

CMS may remove a quality measure from the Hospice QRP based on one or more of the following factors:

[51] National Quality Forum. (2020). *MAP 2020 Considerations for Implementing Measures Final Report—PAC LTC. http://www.qualityforum.org/Publications/2020/02/MAP_2020_Considerations_for_Implementing_Measures_Final_Report_-_PAC_LTC.aspx.*

(1) Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(2) Performance or improvement on a measure does not result in better patient outcomes.

(3) A measure does not align with current clinical guidelines or practice.

(4) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(5) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(6) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(7) Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(8) The costs associated with a measure outweigh the benefit of its continued use in the program.

We solicit public comment on our proposal to revise the regulation at § 418.312(b) to add paragraphs (b)(1) through (3) to include administrative data as part of the HQRP, and correct technical errors identified in the FY 2016 and 2019 Hospice Wage Index and Payment Rate Update final rules.

6. Update Regarding the Hospice Outcomes & Patient Evaluation (HOPE) Development

As finalized in the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), we are developing a hospice patient assessment instrument identified as the HOPE. This tool is intended to help hospices better understand care needs throughout the patient's dying process and contribute to the patient's plan of care. It will assess patients in real-time, based on interactions with the patient. The HOPE will support quality improvement activities and calculate outcome and other types of quality measures in a way that mitigates burden on hospice providers and patients. Our two primary objectives for the HOPE are to provide quality data for the HQRP requirements through standardized data collection, and to provide additional clinical data that could inform future payment refinements.

We anticipate that the HOPE will replace the HIS. The HIS is not a patient assessment instrument. HIS data collection ''consists of selecting responses to HIS items in conjunction with patient assessment activities or via abstraction from the patient's clinical record.'' (HIS Manual v.2.01). In contrast, the HOPE is a patient assessment instrument, designed to capture patient and family care needs in real-time during patient interactions throughout the patient's hospice stay, with the flexibility to accommodate patients with varying clinical needs. The HOPE will enable CMS and hospices to understand the care needs of people through the dying process, supporting provider care planning and quality improvement efforts, and ensuring the safety and comfort of individuals enrolled in hospice nationwide. The HOPE will include key items from the HIS along with Standardized Patient Assessment Data Elements (SPADEs), and demographics like gender and race. This approach to include key aspects of SPADES and demographics supports hospice feedback provided in the FYs 2017 and 2018 Hospice Wage Index and Payment Rate Update final rule (81 FR 52171 and 82 FR 36669) and CMS' goals for a hospice assessment instrument, as stated in the FY 2018 Hospice Wage Index and Payment Rate Update final rule. The HOPE assessment instrument would facilitate communication among providers and to measure the care of patient populations across settings. While the standardization of measures required for adoption under the IMPACT Act of 2014 is not applicable to hospices, it makes reasonable sense to include those standardized elements and items that appropriately and feasibly apply to hospice. After all, some patients may move through the healthcare system to hospice so capturing and tracking key SPADES and social risk factor items that apply to hospice, including some of the categories of SPADES identified in the IMPACT Act of 2014, may help CMS achieve our goals for continuity of care, overall patient care and well-being, interoperability, and health equity that are also discussed in this rule.

The draft HOPE has undergone cognitive and pilot testing, and will undergo field testing to establish reliability, validity and feasibility of the assessment instrument. We anticipate proposing the HOPE in future rulemaking after testing is complete.

We will continue development of the HOPE assessment in accordance with the Blueprint for the CMS Measures Management System. Development of the HOPE is grounded in extensive information gathering activities to identify and refine hospice assessment domains and candidate assessment items. We appreciate the industry's and national associations' engagement in providing input through information sharing activities, including expert interviews, key stakeholder interviews, and focus groups to support the HOPE development. As CMS proceeds with field testing the HOPE, we will continue to engage with stakeholders through sub-regulatory channels. In particular, we will continue to host HQRP Forums to allow hospices and other interested parties to engage with us on the latest updates and ask questions on the development of the HOPE and related quality measures. We also have a dedicated email account, *HospiceAssessment@cms.hhs.gov,* for comments about the HOPE. We will use field test results to create a final version of the HOPE to propose in future rulemaking for national implementation. We will continue to engage all stakeholders throughout this process. We appreciate the support for the HOPE and reiterate our commitment to providing updates and engaging stakeholders through sub-regulatory means. Future updates and engagement opportunities regarding HOPE can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE.html.*

7. Update on Quality Measure Development for Future Years

In the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52160), we finalized new policies and requirements related to the HQRP, including how we would provide updates related to the development of new quality measures. Information on the current HQRP quality measures can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.* In this proposed rule, we are continuing to provide updates for both HOPE-based and claims-based quality measure development.

To support new measure development, our contractor, Abt Associates, convened TEP meetings in 2020 to provide feedback on several measure concepts. In 2020, the TEP explored potential quality measure constructs that could be derived from the HOPE and their specifications. Specifically, for HOPE-based measure development, the TEP focused on pain and other symptom outcome measure concepts that could be calculated from the HOPE. Input from initial TEP workgroups held in spring 2020 informed follow-up information-gathering activities related to pain in general and neuropathic pain in particular. The 2020 Information

Gathering Summary report is available at *https://www.cms.gov/files/document/12042020-information-gathering-oy1508.pdf.* During fall 2020, the TEP reviewed measure concepts focusing on pain and symptom outcomes that could be calculated from HOPE items.

The TEP supported further exploration and development of these measures. As described in the 2020 TEP Summary Report, the TEP generally supports the following measure concepts that are calculated using HOPE items: Timely Reduction of Pain Impact, Reduction in Pain Severity, and Timely Reduction of Symptoms. The candidate measure Timely Reduction of Pain Impact reports the percentage of patients who experienced a reduction in the impact of moderate or severe pain. HOPE items assessing Symptom Impact, and Patient Desired Tolerance Level for Symptoms or Patient Preferences for Symptom Management were used to calculate this measure. The candidate measure Reduction in Pain Severity reports the percentage of patients who had a reduction in reported pain severity. The primary HOPE items used to calculate this measure include Pain Screening, Pain Active Problem, and Patient Desired Tolerance Level for Symptoms or Patient Preferences for Symptom Management. The last candidate measure discussed by the TEP was Timely Reduction of Symptoms which measures the percentage of patients who experience a reduction in the impact of symptoms other than pain. The HOPE items assessing Symptom Impact, and Patient Desired Tolerance Level for Symptoms or Patient Preferences for Symptom Management were used to calculate this measure. The HOPE items for all three measure are collected at multiple time points across a patient's stay, including at Admission, Symptom Reassessment, Level of Care Change, and Recertification. Overall, the TEP supported each candidate measure and agreed that they were viable for distinguishing hospice quality. We continue to develop all three candidate quality measures.

We are interested in exploring patient preferences for symptom management, addressing patient spiritual and psychosocial needs, and medication management in outcomes of care in development of quality measures. We seek public comment, methods, instruments, or brief summaries on hospice quality initiatives related to goal attainment, patient preferences, spiritual needs, psychosocial needs, and medication management.

Information about the TEP feedback on these quality measures concepts and future measure concepts can be obtained via: *https://www.cms.gov/files/document/2020-hqrp-tep-summary-report.pdf.* Related to the outcome measures and in order to have HOPE pain and symptom measures in the program as soon as possible, we plan to develop process measures, including on pain and symptom management. These process measures may support or complement the outcome measures. We solicit comments on current HOPE-based quality measure development and recommendations for future process and outcome measure constructs.

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484) and as discussed below, we are interested in claims-based quality measures in order to leverage the multiple data sources currently available to support quality measure development. Specifically, we intend to develop additional claims-based measures that may enable beneficiaries and their family caregivers to make more informed choices about hospice care and to hold hospices more accountable for the care they provide. As discussed in this section, the HVLDL and HCI claims-based measures support the Meaningful Measures initiative and address gaps in HQRP. Additional claim-based measure concepts we are considering for development include hospice services on weekends, transitions after hospice live discharge, Medicare expenditures per beneficiary (including the share of non-hospice spending during hospice election, and the share for hospice care prior to the last year of life), and post-mortem visits as measures of hospice quality. We intend to submit additional claims-based measures for future consideration and solicit public comment.

We solicit public comment on the aforementioned HOPE- and claims-based quality measures to distinguish between high- and low-quality hospices, support healthcare providers in quality improvement efforts, and provide support to hospice consumers in helping to select a hospice provider. We solicit public comment on how the candidate measures may achieve those goals.

We are 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. Assessment data can be used to support risk-adjustment. We seek public comment on quality measure concepts and considerations for developing hybrid measures based on a combination of data sources.

8. CAHPS Hospice Survey Participation Requirements for the FY 2023 APU and Subsequent Years

a. Background and Description of the CAHPS Hospice Survey

The CAHPS Hospice Survey is a component of the CMS HQRP which is used to collect data on the experiences of hospice patients and the primary caregivers listed in their hospice records. Readers who want more information about the development of the survey, originally called the Hospice Experience of Care Survey, may refer to 79 FR 50452 and 78 FR 48261. National implementation of the CAHPS Hospice Survey commenced January 1, 2015 as stated in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452).

b. Overview of the ''CAHPS Hospice Survey Measures''

The CAHPS Hospice Survey measures was re-endorsed by NQF on November 20, 2020. The re-endorsement can be found on the NQF website at: *https://www.qualityforum.org/Measures_Reports_Tools.aspx.* Use the QPS tool and search for NQF number 2651. The survey received its initial NQF endorsement on October 26, 2016 (NQF #2651). We adopted 8 survey based measures for the CY 2018 data collection period and for subsequent years. These eight measures are publicly reported on a designated CMS website, Care Compare, *https://www.medicare.gov/care-compare/.*

c. Data Sources

We previously finalized the participation requirements for the CAHPS Hospice Survey, (84 FR 38484). We propose no changes to these requirements going forward.

d. Public Reporting of CAHPS Hospice Survey Results

We began public reporting of the results of the CAHPS Hospice Survey on Hospice Compare as of February 2018. Prior to the COVID–19 public health emergency (PHE), we reported the most recent 8 quarters of data on the basis of a rolling average, with the most recent quarter of data being added and the oldest quarter of data removed from the averages for each data refresh. Given the exemptions provided due to COVID–19 PHE in the March 27, 2020 Guidance Memorandum,[52] public reporting will

[52] *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

continue to be the most recent 8 quarters of data, excluding the exempted quarters; Quarter 1 and Quarter 2 of CY 2020. More information about this is detailed in the section entitled: Proposal for Public Reporting CAHPS-based measures with Fewer than Standard Numbers of Quarters Due to PHE Exemptions.

e. Volume-Based Exemption for CAHPS Hospice Survey Data Collection and Reporting Requirements

We previously finalized a volume-based exemption for CAHPS Hospice Survey Data Collection and Reporting requirements for FY 2021 and every year thereafter (84 FR 38526).

We propose no changes to this exemption. The exemption request form is available on the official CAHPS Hospice Survey website: *http://www.hospiceCAHPSsurvey.org.* Hospices that intend to claim the size exemption are required to submit to CMS their completed exemption request form by December 31, of the data collection year.

Hospices that served a total of fewer than 50 survey-eligible decedent/caregiver pairs in the year prior to the data collection year are eligible to apply for the size exemption. Hospices may apply for a size exemption by submitting the size exemption request form as outlined above. The size exemption is only valid for the year on the size exemption request form. If the hospice remains eligible for the size exemption, the hospice must complete the size exemption request form for every applicable FY APU period, as shown in table 19.

TABLE 19: Size Exemption Key Dates FY 2022 Through FY 2026

Fiscal year	Data collection year	Reference year	Size exemption form submission deadline
FY 2022	CY 2020	CY 2019	December 31, 2020
FY 2023	CY 2021	CY 2020	December 31, 2021
FY 2024	CY 2022	CY 2021	December 31, 2022
FY 2025	CY 2023	CY 2022	December 31, 2023
FY 2026	CY 2024	CY 2023	December 31, 2024

f. Newness Exemption for CAHPS Hospice Survey Data Collection and Public Reporting Requirements

We previously finalized a one-time newness exemption for hospices that meet the criteria as stated in the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52181). In the FY 2019 Hospice Wage Index and Payment Rate Update final rule (83 FR 38642), we continued the newness exemption for FY 2023, and all subsequent years. We encourage hospices to keep the letter they receive providing them with their CMS Certification Number (CCN). The letter can be used to show when you received your number.

g. Survey Participation Requirements

We previously finalized survey participation requirements for FY 2022 through FY 2025 as stated in the FY 2018 and FY 2019 Hospice Wage Index and Payment Rate Update final rules (82 FR 36670 and 83 FR 38642 through 38643). We also continued those requirements in all subsequent years (84 FR 38526). Table 20 restates the data submission dates for FY 2023 through FY 2025.

TABLE 20: CAHPS Hospice Survey Data Submission Dates for the APU in FY 2023, FY 2024, and FY 2025

Sample months (month of death)*	CAHPS Quarterly Data Submission Deadlines**
FY 2023 APU	
CY January-March 2021 (Quarter 1)	August 11, 2021
CY April-June 2021 (Quarter 2)	November 10, 2021
CY July-September 2021 (Quarter 3)	February 9, 2022
CY October-December 2021 (Quarter 4)	May 11, 2022
FY 2024 APU	
CY January-March 2022 (Quarter 1)	August 10, 2022
CY April-June 2022 (Quarter 2)	November 9, 2022
CY July-September 2022 (Quarter 3)	February 8, 2023
CY October-December 2022 (Quarter 4)	May 10, 2023
FY 2025 APU	
CY January-March 2023 (Quarter 1)	August 9, 2023
CY April-June 2023 (Quarter 2)	November 8, 2023
CY July-September 2023 (Quarter 3)	February 14, 2024
CY October-December 2023 (Quarter 4)	May 8, 2024

* Data collection for each sample month initiates 2 months following the month of patient death (for example, in April for deaths occurring in January).

** Data submission deadlines are the second Wednesday of the submission months, which are the months August, November, February, and May.

For further information about the CAHPS Hospice Survey, we encourage hospices and other entities to visit: *https://www.hospiceCAHPSsurvey.org.* For direct questions, contact the CAHPS Hospice Survey Team at *hospiceCAHPSsurvey@HCQIS.org* or call 1-(844) 472–4621.

h. Proposal To Add CAHPS Hospice Survey Star Ratings to Public Reporting

CMS currently publishes CAHPS star ratings for several of its public reporting programs including Home Health CAHPS and Hospital CAHPS. The intention in doing so is to provide a simple, easy to understand, method for summarizing CAHPS scores. Star ratings benefit the public in that they can be easier for some to understand than absolute measure scores, and they make comparisons between hospices more straightforward. The public's familiarity with a 1 through 5 star rating system, given its use by other programs, is also a benefit to using this system.

We propose to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare or successor websites no sooner than FY 2022. We propose that the calculation and display of the CAHPS Hospice Survey Star Ratings be similar to that of other CAHPS Star Ratings programs such as Hospital CAHPS and Home Health CAHPS. The stars would range from one star (worst) to five stars (best). We propose that the stars be calculated based on ''top-box'' scores for each of the eight CAHPS Hospice Survey measures. Specifically, individual-level responses to survey items would be scored such that the most favorable response is scored as 100 and all other responses are scored as 0. A hospice-level score for a given survey item would then be calculated as the average of the individual-level responses, with adjustment for differences in case mix and mode of survey administration. For a measure composed of multiple items, the hospice-level measure score is the average of the hospice-level scores for each item within the measure. Similar to other CAHPS programs, we propose that the cut-points used to determine the stars be constructed using statistical clustering procedures that minimize the score differences within a star category and maximize the differences across star categories.

We propose to use a two-stage approach to calculate these cut-points. In the first stage, we would determine initial cut-points by calculating the clustering algorithm among hospices with 30 or more completed surveys over 2 quarters (that is, 6 months); restricting these calculations to hospices that meet a minimum sample size promotes stability of cut-points. Depending on whether hospices that meet this minimum sample size have different score patterns than smaller hospices, the initial cut-points may be too high or too low. To ensure that cut-points reflect the full distribution of measure performance, in the second stage, we would compare mean measure scores for the bigger hospices used in the first stage to all other hospices, and update cut-points by adjusting the initial cut-points to reflect the normalized difference between bigger and smaller hospices. This two-stage approach allows for calculation of stable cut-points that reflect the full range of hospice performance. We propose that hospice star ratings for each measure be assigned based on where the hospice-level measure score falls within these cut-points.

We further propose to calculate a summary or overall CAHPS Hospice Survey Star Rating by averaging the Star Ratings across the 8 measures, with a weight of ½ for Rating of the Hospice, a weight of ½ for Willingness to Recommend the Hospice, and a weight of 1 for each of the other measures, and then rounding to a whole number. We propose that only the overall Star Rating be publicly reported and that hospices must have a minimum of 75 completed surveys in order to be assigned a Star Rating. We propose to publish the details of the Star Ratings methodology on the CAHPS Hospice Survey website, *www.hospicecahpssurvey.org.* CMS requires no additional resources to create and display CAHPS star ratings.

We solicit comments on these proposals for CAHPS Star Ratings and included in public reporting no sooner than FY 2022.

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

a. Background

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act was amended by the CAA 2021 and the payment reduction for failing to meet hospice quality reporting requirements is increased from 2 percent to 4 percent beginning with FY 2024. The Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and then beginning in FY 2024 and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

b. Compliance

HQRP Compliance requires understanding three timeframes for both HIS and CAHPS. (1) The relevant Reporting Year, payment FY and the Reference Year. The ''Reporting Year'' (HIS)/''Data Collection Year'' (CAHPS). This timeframe is based on the CY. It is the same CY for both HIS and CAHPS. If the CAHPS Data Collection year is CY 2022, then the HIS reporting year is also CY 2022. (2) The APU is subsequently applied to FY payments based on compliance in the corresponding Reporting Year/Data Collection Year. (3) For the CAHPS Hospice Survey, the Reference Year is the CY prior to the Data Collection Year. The Reference Year applies to hospices submitting a size exemption from the CAHPS survey (there is no similar exemption for HIS). For example, for the CY 2022 data collection year, the Reference Year, is CY 2021. This means providers seeking a size exemption for CAHPS in CY 2022 would base it on their hospice size in CY 2021. Submission requirements are codified in § 418.312.

For every CY, all Medicare-certified hospices are required to submit HIS and CAHPS data according to the requirements in § 418.312. Table 21 summarizes the three timeframes described above. It illustrates how the CY interacts with the FY payments, covering the CY 2020 through CY 2023 data collection periods and the corresponding APU application from FY 2022 through FY 2025.

TABLE 21: HQRP Reporting Requirements and Corresponding Annual Payment Updates

Reporting Year for HIS and Data Collection Year for CAHPS data (Calendar year)	Annual Payment Update Impacts Payments for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2020	FY 2022 APU	CY 2019
CY 2021	FY 2023 APU	CY 2020
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022

* Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment

As illustrated in Table 21, CY 2020 data submissions compliance impacts the FY 2022 APU. CY 2021 data submissions compliance impacts the FY 2023 APU. CY 2022 data submissions compliance impacts FY 2024 APU. This CY data submission impacting FY APU pattern follows for subsequent years.

c. Submission Data and Requirements

As finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47192), hospices' compliance with HIS requirements beginning with the FY 2020 APU determination (that is, based on HIS-Admission and Discharge records submitted in CY 2018) are based on a timeliness threshold of 90 percent. This means CMS requires that hospices submit 90 percent of all required HIS records within 30-days of the event (that is, patient's admission or discharge). The 90-percent threshold is hereafter referred to as the timeliness compliance threshold. Ninety percent of all required HIS records must be submitted and accepted within the 30-day submission deadline to avoid the statutorily-mandated payment penalty.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey. Hospices comply by utilizing a CMS-approved third-party vendor. Approved Hospice CAHPS vendors must successfully submit data on the hospice's behalf to the CAHPS Hospice Survey Data Center. A list of the approved vendors can be found on the CAHPS Hospice Survey website: *www.hospicecahpssurvey.org.* Table 22. HQRP Compliance Checklist illustrates the APU and timeliness threshold requirements.

TABLE 22: HQRP Compliance Checklist

Annual Payment Update	HIS	CAHPS
FY 2022	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/20 – 12/31/20.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2020 – 12/31/2020
FY 2023	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/21 – 12/31/21.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2021 – 12/31/2021
FY 2024	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/22 – 12/31/22.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2022 – 12/31/2022

Most hospices that fail to meet HQRP requirements do so because they miss the 90 percent threshold. We offer many training and education opportunities through our website, which are available 24/7, 365 days per year, to enable hospice staff to learn at the pace and time of their choice. We want hospices to be successful with meeting the HQRP requirements. We encourage hospices to use this website at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training-Training-and-Education-Library.*

For more information about HQRP Requirements, please visit the frequently-updated HQRP website and especially the Best Practice, Education and Training Library, and Help Desk web pages at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting.* We also encourage members of the public to go to the HQRP web page and sign-up for the Hospice Quality ListServ to stay informed about HQRP.

d. Update on Transition to iQIES

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we finalized the proposal to migrate our systems for submitting and processing assessment data. 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 Wage Index and Payment Rate Update final rule (84 FR 38484) finalized the proposal to migrate to a new internet Quality Improvement and Evaluation System (iQIES) that will enable us to make real-time upgrades. We are designating that system as the data submission system for the Hospice QRP. We will notify the public about any system migration updates using subregulatory mechanisms such as web page postings, listserv messaging, and webinars.

10. Public Display of ''Quality Measures'' and Other Hospice Data for the HQRP

a. Background

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any quality data submitted by hospices available to the public. These procedures shall ensure that individual hospices have the opportunity to review their data prior to these data being made public on our designated public website. To meet the Act's requirement for making quality measure data public, we launched Hospice Compare in August 2017. This website allows consumers, providers, and other stakeholders to search for all Medicare-certified hospice providers and view their information and quality measure scores. In September 2020, CMS transitioned Hospice Compare to the *Care Compare* website. Hospice Compare was discontinued in December 2020. Care Compare supports all Medicare settings and fulfills the Act's requirements for the HQRP. For more information about Care Compare, please see the Update on the Hospice Quality Reporting Requirements for FY 2022 in section D.

Since 2017, we have increased and improved available information about the care hospices provide for consumers. To indicate the quality of care hospices provide, we first posted the seven HIS Measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617) in 2017, and then added the CAHPS Hospice Survey measure (NQF #2651) and the HIS Comprehensive Assessment at Admission (NQF #3235) in 2018. In 2019, we added the Hospice Visits When Death is Imminent (Measure 1) to the website.

As discussed above, we propose to remove the seven HIS Measures from public reporting on Care Compare no earlier than May 2022. The Hospice Item Set V3.00 PRA Submission replaced the HVWDII measure with a more robust version: The claims-based measure HVLDL. We propose to publicly report the HVLDL no earlier than May 2022. We are also proposing to publicly report the HCI, another claims-based measure no earlier than May 2022. In addition to the publicly-reported quality measure data, in 2019 we added to public reporting, information about the hospices' characteristics, taking raw data available from the Medicare Public Use File and other publicly-available government data sources and making them more consumer friendly and accessible for people seeking hospice care for themselves or family members, (83 FR 38649). This publicly reported information currently includes diagnoses, location of care, and levels of care provided.

b. Proposal Regarding Data Collection and Reporting During a Public Health Emergency

(1). Background: COVID–19 Public Health Emergency Temporary Exemption and Its Impact on the Public Reporting Schedule

Under authority of section 319 of the Public Health Service (PHS) Act, the Secretary declared a Public Health Emergency (PHE) effective as of January 27, 2020. On March 13, 2020, the President declared a national state of emergency under the Stafford Act, effective March 1, 2020, allowing the Secretary to invoke section 1135(b) of the Act (42 U.S.C. 1320b–5) to waive or modify the requirements of titles XVIII, XIX, and XXI of the Act and regulations to the extent necessary to address the COVID–19 PHE. Many waivers and modifications were made effective as of March 1, 2020 [53] [54] in accordance with the president's declaration. On March 27, 2020, we sent a guidance memorandum under the subject title, ''Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID–19'' [55] to the Medicare Learning Network (MLN) Connects Newsletter and Other Program-Specific Listserv Recipients,[56] hereafter referred to as the March 27, 2020 CMS Guidance Memorandum. In that memo, which applies to HIS and CAHPS Hospice Survey, CMS granted an exemption to the HQRP reporting requirements for Quarter 4 (Q4) 2019 (October 1, 2019 through December 31, 2019), Quarter 1 (Q1) 2020 (January 1, 2020 through March 30, 2020), and Quarter 2 (Q2) 2020 (April 1, 2020 through June 30, 2020). We discuss the impact to the HIS here, and the impact to the CAHPS Hospice Survey further below. For HIS, the quarters are defined based on submission of HIS admission or discharge assessments.

The exemption has impacted the public reporting schedule. Since launching Hospice Compare in 2017, HIS-measures have been reported using 4 quarters of data. The 4 quarters included are the most recent data that have gone through Review and Correct processes, have been issued in a provider preview report, and have time allotted for addressing requests for data suppression before being publicly reported. As discussed in the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52183), CMS requires at least 4 quarters of data to establish the scientific acceptability for our HIS-based quality measures. For CAHPS-based measures, we have reported CAHPS measures using eight rolling quarters of data on Hospice Compare since 2018. In the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52143), we stated that we would continue CAHPS reporting with eight rolling quarters on an ongoing basis. This original public reporting schedule included the exempted quarters of Q4 2019 and Q1 and Q2 2020 in six refreshes for HIS and 11 refreshes for CAHPS. Table 23 displays the original schedule for public reporting prior to the COVID–19 PHE.

[53] Azar, A.M. (2020 March 15). *Waiver or Modification of Requirements Under Section 1135 of the Social Security Act.* Public Health Emergency. *https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx.*

[54] *https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx.*

[55] *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

[56] (2020, March 27). Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID–19. Centers for Medicare & Medicaid Services. *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

TABLE 23: Original Public Reporting Schedule with Refreshes Affected by PHE Exemptions for the HQRP

Quarter Refresh	HIS Quarters in Original Schedule for Care Compare	CAHPS Quarters in Original Schedule for Care Compare
*November 2020	Q1 2019- Q4 2019	Q1 2018-Q4 2019
*February 2021	Q2 2019- Q1 2020	Q2 2018-Q1 2020
*May 2021	Q3 2019-Q2 2020	Q3 2018-Q2 2020
*August 2021	Q4 2019- Q3 2020	Q4 2018-Q3 2020
*November 2021	Q1 2020- Q4 2020	Q1 2019-Q4 2020
*February 2022	Q2 2020-Q1 2021	Q2 2019-Q1 2021
†May 2022	Q3 2020-Q2 2021	Q3 2019-Q2 2021
†August 2022	Q4 2020-Q3 2021	Q4 2019-Q3 2021
†November 2022	Q1 2021-Q4 2021	Q1 2020-Q4 2021
†February 2023	Q2 2021-Q1 2022	Q2 2020-Q1 2022
†May 2023	Q3 2021-Q2 2022	Q3 2020-Q2 2022

*Exemption affects both HIS and CAHPS data for refresh; †Exemption affects only CAHPS data for refresh.

During the spring and summer of 2020, we conducted testing to inform decisions about publicly reporting data for those refreshes which include exempt data. The testing helped us develop a plan for posting data as early as possible, for as many hospices as possible, and with scientific acceptability similar to standard threshold for public reporting. The following sections provide the results of our testing and explain how we used the results to develop a plan that we believe allows us to achieve these objectives as best as possible.

(2). Update on Use of Q4 2019 Data and Data Freeze for Refreshes in 2021

In the March 27, 2020 Guidance Memorandum, we stated that we should not include any post-acute care (PAC) quality data that are greatly impacted by the exemption in the quality reporting programs. Given the timing of the PHE onset, we determined that we would use any data that was submitted for Q4 2019. We conducted analyses of those data to ensure that their use was appropriate. In the original schedule (Table 23) the November 2020 refresh includes Q4 2019 data for HIS- and CAHPS-based measures (Q1 through Q4 2019 for HIS data and Q1 2018 through Q4 2019 for CAHPS data) and is the last refresh before Q1 2020 data are included. Before proceeding with the November 2020 refresh, we conducted testing to ensure that, even though we made an exception to reporting requirements for Q4 2019 in March 2020, public reporting would still allow us to publicly report data for a similar number of hospice providers, as compared to standard reporting. Specifically, we compared submission rates in Q4 2019 to average annual rates (Q4 2018 through Q3 2019) to assess the extent to which hospices had taken advantage of the exemption, and thus the extent to which data and measure scores might be affected. We observed that the HIS data submission rate for Q4 2019 was in fact 1.8 percent higher than the previous CY (Q4 2018). For the CAHPS Hospice Survey, 2.1 percent more hospices submitted data in Q4 2019 than in Q4 2018. We note that Q4 2019 ended before the onset of the COVID–19 PHE in the United States (U.S.). Thus, we proceeded with including these data in measure calculations for the November 2020 refresh.

As for Q1 and Q2 2020, we determined that we would not use HIS or CAHPS data from these quarters for public reporting given the timing of the PHE onset. All refreshes, during which we decided to hold these data constant, included more than 2 quarters of data that were affected by the CMS-issued COVID reporting exceptions; thus we did not have an adequate amount of data to reliably calculate and publicly display provider measures scores. Consequently, we determined to freeze the data displayed, that is, holding data constant after the November 2020 refresh without subsequently updating the data through November 2021. This decision was communicated to the public in a Public Reporting Tip Sheet, which is located at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.*

(3). Proposal for Public Reporting of HIS-Based Measures With Fewer Than Standard Numbers of Quarters Due to PHE Exemption in February 2022

As noted above, we used Q4 2019 data for public reporting in November 2020 and froze that data for the February, May, August, and November 2021 refreshes. This addressed five of the six PHE-affected quarters for HIS-based measures, and five of the 11 PHE-affected quarters of CAHPS-based measures.

Because November 2020 refresh data will become increasingly out-of-date and thus less useful for consumers, we analyzed whether it would be possible to use fewer quarters of data for the last refresh affected by the exemption (February 2022) and thus more quickly resume public reporting with updated quality data. Using fewer quarters of more recent data, the first option, would require that (1) a sufficient percentage of providers would still likely have enough assessment data to report quality measures (reportability); and (2) fewer quarters would likely produce similar measure scores for hospices, and thus not unfairly represent the quality of care hospices provide during the period reported in a given refresh (reliability). To assess these criteria, we conducted reportability and reliability analysis using 3 quarters of data in a refresh, instead of the standard 4 quarters of data for reporting HIS-based measures. Specifically, we used historical data to calculate HIS-based quality measures under two scenarios:

- Standard Public Reporting (SPR) Scenario: We used data from the four quarters of CY 2019, which represent CY 2020 public reporting in the absence of the temporary exemption from the submission of PAC quality data, as the basis for comparing simulated alternatives. For HIS-based measures, we used quarters Q1 through Q4 2019.
- COVID–19 PHE Affected Reporting (CAR) Scenario: We calculated quality measures using Q2 2019, Q3 2019, and Q4 2019 data, to simulate using only Q3 2020, Q4 2020, and Q1 2021 data for public reporting.

The HIS Comprehensive Assessment Measure is based on the receipt of care processes at the time of admission. Therefore for the COVID–19 Affected Reporting (CAR) Scenario, we excluded data for patient stays with admission dates in Q1 2019.

For each scenario, we calculated the reportability as the percent of hospices meeting the 20-case minimum for public reporting (the public reporting threshold). To test the reliability of restricting the providers included in the Standard Public Reporting (SPR) Scenario to those included in the CAR Scenario, we performed three tests. First, we evaluated measure correlation using the Pearson and Spearman correlation coefficients, which assess the alignment of hospices' HIS Comprehensive Assessment Measure scores between scenarios. Second, for each scenario, we conducted a split-half reliability analysis and estimated intra-class correlation (ICC) scores, where higher scores imply better internal reliability. Modest differences in ICC scores between scenarios would suggest that using fewer quarters of data does not impact the internal reliability of the results. Third, we estimated reliability scores. A higher value in these scores indicates that HIS Comprehensive Assessment Measure values are relatively consistent for patients admitted to the same hospice and variation in the measure reflects true differences across providers.

Testing results show that the CAR scenario—specifically using 3 quarters of data for the HIS Comprehensive Assessment Measure—demonstrates acceptable levels of reportability and reliability. As displayed in Table 24, the number of providers who met the public reporting threshold for the HIS Comprehensive Assessment Measure decreases by 236 (or by 5.2 percentage points) when reporting three versus four quarters of data. In the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48234) we stated that reportability of 71 percent through 90 percent is acceptable. Therefore using 3 quarters of data for the HIS Comprehensive Assessment Measure would achieve acceptable reportability shown in Table 24.

TABLE 24: Reportability: Percent of Providers Meeting Measure Public Reporting Thresholds

	Reportability		
Measure	COVID-19 Affected Reporting (CAR) Met Threshold # (%) Providers	Standard Public Reporting (SPR) Met threshold # (%) Providers	Difference (CAR -SPR)
HIS Comprehensive Assessment Measure	3,842 (83.9%)	4,078 (89.1%)	-236 (-5.2%)

Table 24 indicates that the reliability of the HIS Comprehensive Assessment Measure scores is similar for the CAR and SPR scenarios. Testing also yielded correlation coefficients above 0.9, indicating a high degree of agreement between hospices' HIS Comprehensive Assessment Measure scores when using 3 or 4 quarters of data. The results also show that the HIS Comprehensive Assessment Measure's ICC for CAR and SPR scenarios are similar, with only a 0.02 difference. This implies high internal reliability of the measure in both scenarios. The median reliability scores for the HIS Comprehensive Assessment Measure are also very similar in both CAR and SPR scenarios. This indicates that scores estimated using 3 quarters of data continue to capture provider-level differences and that admission-level scores remain consistent within hospices.

TABLE 25: Reliability: Correlations, Split-Half Testing, and Reliability Score for COVID-19 Affected (CAR) and Standard Public Reporting (SPR) Scenarios

	Correlation between CAR and SPR		Split-Half Reliability Testing			Reliability Score		
Measure	Pearson	Spearman	ICC (CAR)	ICC (SPR)	Difference (CAR - SPR)	Median Score (CAR)	Median Score (SPR)	Difference (CAR - SPR)
HIS Comprehensive Assessment Measure	0.98	0.96	0.95	0.93	0.02	97.5	97.7	-0.2

ICC = raIntra-class Coefficient

In Table 25, we explore changes in hospices' relative rankings between the SPR and CAR scenarios. For each scenario, we divided hospices in quintiles based on their HIS Comprehensive Assessment Measure score, such that higher scores are in a higher quintile. Changes in a hospices' quintile from the SPR to CAR scenario would indicate a re-ranking of hospices when using 3 quarters compared to 4 quarters. Over 93 percent of hospices remain in the same quintile, suggesting that the ranking of hospices is fairly stable between the SPR and CAR scenarios.

TABLE 26: Performance: Comparison of Quintile Rankings between COVID-19 PHE Affected (CAR) and Standard Public Reporting (SPR) Scenarios

	Overall			Rural Providers			Urban Providers		
Measure	% Same Quintile	% CAR Lower Quintile	% CAR Higher Quintile	% Same Quintile	% CAR Lower Quintile	% CAR Higher Quintile	% Same Quintile	% CAR Lower Quintile	% CAR Higher Quintile
HIS Comprehensive Assessment Measure	93.4%	2.4%	4.2%	93.5%	2.1%	4.4%	93.3%	2.5%	4.2%

We also used the results presented in Table 26 to assess the option of reporting Q4 2019, Q3 2020, Q4 2020, and Q1 2021 for the February 2022 refresh. This option maintains requirements in the FY 2017 Hospice Wage Index and Payment Update final rule for publicly reporting 4 quarters of data, but it requires using some data that are more than 2 years old. Also, the relatively high number of hospices that meet the public reporting threshold in the CAR scenario, relative to the SPR scenario, with just 3 quarters of data justify the use of 3 quarters in the unusual circumstances of the PHE and its associated exemptions.

We propose that, in the COVID–19 PHE, we would use 3 quarters of HIS data for the final affected refresh, the February 2022 public reporting refresh of Care Compare for the Hospice setting. Using 3 quarters of data for the February 2022 refresh would allow us to begin displaying Q3 2020, Q4 2020, and Q1 2021 data in February 2022, rather than continue displaying November 2020 data (Q1 2019 through Q4 2019). We believe that updating the data in February 2022 by more than a year relative to the November 2020 freeze data would assist consumers by providing more relevant quality data and allow hospices to demonstrate more recent performance. Our testing results indicate we can achieve these positive impacts while maintaining high standards for reportability and reliability. Table 27 summarizes the comparison between the original schedule for public reporting with the revised schedule (that is, frozen data) and with the proposed schedule that is, using 3 quarters in the February 2022 refresh.

We seek public comment on this proposal to use 3 quarters of HIS data for the February 2022 public reporting refresh.

TABLE 27: Original, Revised, and Proposed Schedule for Refreshes Affected by COVID-19 PHE Exemptions

Quarter Refresh	HIS Quarters in Original Schedule for Care Compare (number of quarters)	HIS Quarters in revised/proposed Schedule for Care Compare (number of quarters)
November 2020	Q1 2019- Q4 2019 (4)	Q1 2019- Q4 2019 (4)
February 2021	Q2 2019- Q1 2020 (4)	Q1 2019- Q4 2019 (4)
May 2021	Q3 2019-Q2 2020 (4)	Q1 2019- Q4 2019 (4)
August 2021	Q4 2019- Q3 2020 (4)	Q1 2019- Q4 2019 (4)
November 2021	Q1 2020- Q4 2020 (4)	Q1 2019- Q4 2019 (4)
February 2022	Q2 2020-Q1 2021 (4)	Q3 2020-Q1 2021 (3)

Note: The shaded cells represent data frozen due to COVID-19 PHE.

(4). Proposal for Public Reporting of ''CAHPS Hospice Survey-Based Measures'' Due to PHE Exemption

Prior to COVID–19 PHE, the CAHPS Hospice Survey publicly reported the most recent eight rolling quarters of data. We propose to continue to report the most recent 8 quarters of available data after the freeze, but not to include the data from the exempted quarters of Q1 and Q2 of 2020 as issued in the March 27, 2020 Guidance Memorandum with the effected quarters discussed above. The optional data submission for Q4 2019 results in publicly reporting of that data since the CAHPS Hospice Survey from that quarter were not impacted. The data submitted for Q4 2019 referred to deaths that occurred prior to COIVD–19. For the CAHPS Hospice Survey, 2.1 percent more hospices submitted data in Q4 2019 than in the same quarter a year earlier.

Like HIS, our goal is to report as much of the most recent CAHPS Hospice Survey data as possible, to display data for as many hospices as possible, and to maintain the reliability of the data.

Similar to HIS, the CAHPS Hospice Survey reviewed the data for reportability using fewer quarters than normal. However, we found that using fewer than 8 quarters of data would have two important negative impacts on public reporting. First, it would reduce the proportion of hospices that would have CAHPS Hospice Survey data displayed on Care Compare. An analysis of the 8 quarters of data from Q1 2018 through Q4 2019 (publicly reported in November 2020) shows there were 5,041 active hospices. Of these hospices: 2,941 (58.3 percent) had 30+ completes for those 8 quarters, and had scores publicly reported. Fewer hospices, 2,328 (46.2 percent), would have had 30+ completes if 4 quarters of data were used to calculate scores and 1,970 (39.1 percent) would have 30+ completes if 3 quarters were used to calculate scores. In addition, the overall reliability of the CAHPS scores would decline with fewer quarters of data. For these reasons, we determined the best course of action would be to continue to publicly report the most recent 8 quarters of data, but exempting Q1 and Q2 2020. This will allow us to maximize the number of hospices that will have CAHPS scores displayed on Care Compare, protect the reliability of the data, and report as much of the most recent data as possible.

CMS froze CAHPS data starting with the November 2020 refresh and concluding with the November 2021 refresh. We propose that starting with the February 2022 refresh, CMS will display the most recent 8 quarters of CAHPS Hospice Survey data, excluding Q1 and Q2 2020. We will resume public reporting by displaying 3 quarters of post-exemption data, plus five quarters of pre-exemption data. (Please see Table 28.) We propose that in each refresh subsequent to February 2022, we will report one more post-exemption quarter of data and one fewer pre-exemption quarter of data until we reach eight quarters of post-exemption data in May of 2023. We further propose that as of August 2023, we will resume reporting a rolling average of the most recent 8 quarters of data. Table 28 specifies the quarters for each refresh. This will allow us to report the maximum amount of new data, maintain reliability of the data, and permit the maximum number of hospices to receive scores. In addition, Table 28 shows the proposed CAHPS public reporting schedule during and after the data freeze.

TABLE 28: Proposed CAHPS Hospice Survey Public Reporting Quarters During and After the Freeze

Refresh	Publicly Reported Quarters
Freeze:	*Q1 2018-Q4 2019*
*November 2020-November 2021**	
February 2022	Q4 2018 – Q4 2019, Q3 2020 – Q1 2021
May 2022	Q1 2019-Q4 2019, Q3 2020-Q2 2021
August 2022	Q2 2019-Q4 2019, Q3 2020-Q3 2021
November 2022	Q3 2019-Q4 2019, Q3 2020-Q4 2021
February 2023	Q4 2019, Q3 2020-Q1 2022
May 2023	Q3 2020-Q2 2022
*The grey shading refers to the frozen quarters.	

We seek public comment on this proposal to publicly report the most-recently available 8 quarters of CAHPS data starting with the February 2022 refresh and going through the May 2023 refresh on Care Compare because we cannot publicly report Q1 2020 and Q2 2020 data due to the COVID–19 PHE.

c. Quality Measures To Be Displayed on Care Compare in FY 2022 and Beyond

(1). Proposal To Remove Seven ''Hospice Item Set Process Measures'' From Public Reporting

As discussed earlier, we are proposing to remove the seven HIS process measures from the HQRP as individual measures, and no longer applying them to the FY 2024 APU and thereafter. We propose to remove the seven HIS process measures no earlier than May 2022 refresh from public reporting on Care Compare and from the Preview Reports but continue to have it publicly available in the data catalogue at *https://data.cms.gov/provider-data/topics/hospice-care.* We are seeking public comment on this proposal to remove the seven HIS process measures from public reporting on Care Compare.

(2). Proposals for Calculating and Publicly Reporting ''Claims-Based Measure'' as Part of the HQRP

In the HIS V3.00 Paperwork Reduction Act Submission (OMB control number: 0938–1153, CMS–10390), we finalized a proposal to adopt HVLDL into the HQRP for FY 2021. We are also proposing in this rule, discussed above, to adopt the HCI into the HQRP for FY2022. In this section, we present four proposals related to calculating and reporting claims-based measures, with specific application to HVLDL and HCI. First, we propose to extract claims data to calculate claims-based measures at least 90 days after the last discharge date in the applicable period, which we will use for quality measure calculations and public reporting on Care Compare. For example, if the last discharge date in the applicable period for a measure is December 31, 2022, for data collection January 1, 2022, through December 31, 2022, we would create the data extract on approximately March 31, 2023, at the earliest. We would use those data to calculate and publicly report the claims-based measures for the CY2022 reporting period. This proposal is similar to those finalized in other PAC settings, including the CY 2017 Home Health Prospective Payment System final rule (81 FR 76702), FY 2017 Inpatient Rehabilitation Facility Prospective Payment System final rule (81 FR 52056), and the FY 2017 Long Term Care Hospital Prospective Payment System final rule (81 FR 56762).

The proposed timeframe allows us to balance providing timely information to the public with calculating the claims-based measures using as complete a data set as possible. We recognize that the proposed approximately 90-day ''run-out'' period is shorter than the Medicare program's current timely claims filing policy under which providers have up to 1 year from the date of discharge to submit claims. However, several months lead-time is necessary after acquiring the data to conduct the claims-based calculations. If we were to delay our data extraction point to 12 months after the last date of the last discharge in the applicable period, we would not be able to deliver the calculations to hospices sooner than 18 to 24 months after the last discharge.

To implement this process, hospices would not be able to submit corrections to the underlying claims snapshot or add claims (for those claims-based measures) to this data set at the

conclusion of the 90-day period following the last date of discharge used in the applicable period. Therefore, we would consider the hospice claims data to be complete for purposes of calculating the claims-based measures at this point. Thus, it is important that hospices ensure the completeness and correctness of their claims prior to the claims ''snapshot.''

Second, we propose that we will update the claims-based measures used for the HQRP annually. Specifically, we will refresh claims-based measure scores on Care Compare, in preview reports, and in the confidential CASPER QM preview reports annually. This periodicity of updates aligns with most claims-based measures across PAC settings.

Third, we propose that we will calculate claims-based measure scores based on one or more years of data. We considered several factors to determine the number of years to include in measure calculations. Using only 1 year (4 quarters) of data, as is currently done for HIS-based quality measures reported on Care Compare, allows us to share with the public only the most up-to-date information and best reflects current realities. Having only the most recent data can also help incentivize hospices with lower scores to make changes and have the results of their effort be reflected in better scores.

At the same time, we want to report measures scores to the public for as many hospices as possible, including small hospices. Currently, only Medicare-certified hospices with more than 20 discharges each year have quality measure results publicly available on Care Compare. This public reporting threshold protects the privacy of patients who seek care at smaller hospices. However, due to the threshold, at least some hospices will not achieve the minimum patient discharges within 1 year. This means that their scores will not be displayed on Care Compare, and consumers will not have information about them to inform their decisions about selecting a hospice. Using more years of data allows more of these hospices to meet this threshold.

We conducted reportability testing for HCI and HVLDL to help us consider how best to balance the need for recent data with the need for transparency in reporting the HQRP claims-based measures. Specifically, we conducted a simulation using 2 years of data. We then calculated the change in the number of hospices which achieved the minimum reporting standard. We also compared the measure scores of the hospices that meet the reporting threshold when we use 2 years of data with hospices that meet the threshold using only 1 year of data.

Results for both HCI and HVLDL indicate that using 2 years of data increases reportability. For HVLDL, combining 2 years of data (FY 2018 to FY 2019) allows an additional 326 hospices to share measure scores, or 33.8 percent of the hospices that do not meet the reporting threshold in FY 2019 alone. For HCI, combining 2 years of data (FY 2018 to FY 2019 data) allows an additional 277 to report HCI measure scores on Care Compare, or 43.2 percent of the hospices that do not meet the reporting threshold in FY 2019 alone.

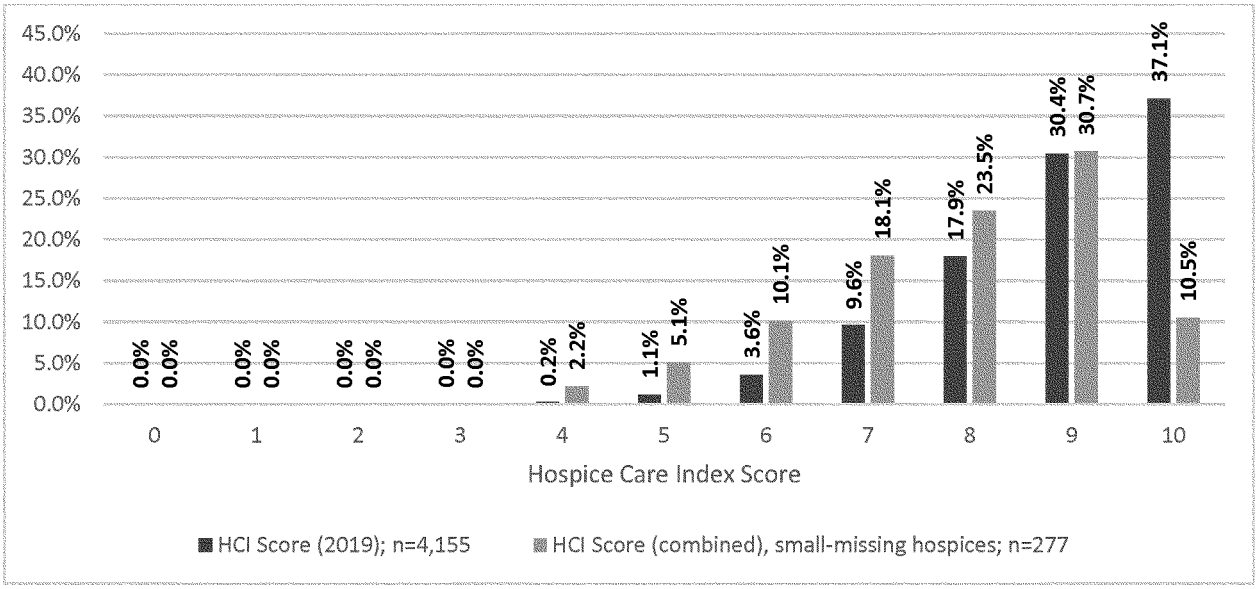
TABLE 29: Two years of Data Increases Reportability for HVLDL and HCI

Quality Measure	Excluded hospices when using one year of data (FY 2019) alone	Additional hospices meeting threshold with two years of data (FY 2018 – FY 2019), relative to FY 2019 alone	% of hospices that did not meet threshold in FY 2019
HVLDL	965	326	33.8%
HCI	641	277	43.2%

Our simulations indicate that the hospices that only meet the reporting threshold when using 2 years of data have performance scores substantially lower than average. For HVLDL, where higher scores indicate better quality of care, the national average score was 65.5 percent in FY 2019, where 965 hospices did not meet the reportability threshold. After pooling data using FY 2018 to FY 2019, 326 additional hospices met the reportability threshold, or 33.8 percent of those previously missing. Those addition 326 hospices had an average HVLDL score of just 43.3 percent, about 20 percentage points lower than the hospices meeting the reportability threshold using FY 2019 alone national average score for this HVLDL measure.

The results for HCI similarly show that the hospices with reportable data when using two-pooled years of data had lower HCI scores compared to the national average when using just FY 2019 data. Higher HCI scores indicate better performance. As Figure 7 shows, a larger numbers of hospices among the 277 hospices that only meet the reporting threshold when using 2 years of data had HCI scores between four and eight, while a larger number of hospices in the FY 2019 population had a perfect score of 10.

Figure 7: Percent of hospices meeting the public reporting threshold based on 1 (FY 2019) or 2 pooled years (FY 2018 to FY 2019) of data, by Hospice Care Index score



Source: 100% Medicare claims, Federal Fiscal Years 2018-2019.

Given these findings, we propose using 2 years of data to publicly report HCI and HVLDL in 2022. The use of 2 years or 8 quarters of quality data is already publicly reported for the quality measures related to the CAHPS Hospice Survey so hospices are familiar with this approach. We plan to consider multiple years of data, like the 2 years of data, for other claims-based measures proposed in subsequent years. We believe it is important to support consumers by sharing information on the performance of hospices that have lower scores, and to incentivize those hospices to improve. The results demonstrate that using multiple years of data help include more hospices that have lower performance rates for HVLDL and HCI in public reporting on Care Compare. While using more years of data would allow us to report measures for even more hospices, it would involve sharing data that are no longer relevant, and display scores that do not reflect recent hospice improvement efforts.

We are soliciting public comment on these proposals related to the using 2 years of data for claims-based measures and public reporting of claims measures in general and their application to HVLDL and HCI specifically.

(3). Proposal To Publicly Report the Hospice Care Index and ''Hospice Visits in the Last Days of Life'' Claims-Based Measures

As discussed previously, we are proposing to publicly report the HCI and HVLDL using 2 years, which is 8 quarters of Medicare claims data. We propose to publicly report the HCI and HVLDL beginning no earlier than May 2022 using FY2021 Medicare hospice claims data, and to include it in the Preview Reports no sooner than the May 2022 refresh. The publicly-reported version of HCI on Care Compare will only include the final HCI score, and not the component indicators. The Preview Reports will reflect the HCI as publicly reported. We are seeking public comment on this proposal for HCI and HVLDL public reporting on Care Compare no sooner than May 2022.

(4). Update on Publicly Reporting for the ''Hospice Visits When Death is Imminent (HVWDII) Measure 1'' and the ''Hospice Visits in the Last Days of Life (HVLDL) Measure''

As discussed earlier, the HIS V3.00 PRA Submission, CMS–10390 (OMB control number: 0938–1153), finalized the proposal to replace the HVWDII measure pair with a re-specified version called HVLDL, which is a single measure based on Medicare claims. Relatedly, in the HIS V3.00 PRA Submission, CMS–10390 (OMB control number: 0938–1153), we finalized the proposal to remove Section O from the HIS. As stated in section 1814(i)(5)(E) of the Act, we establish procedures for making all quality data submitted by hospices under § 418.312 available to the public. Thus, we would have continued to publicly report HVWDII Measure 1 data through the November 2021 refresh. Because of the data freeze detailed above, HVWDII Measure 1 data from the November 2020 refresh, covering HIS admissions during Q1 through Q4 2019, will be publicly displayed for all calendar year 2021 refreshes. We may retain the November 2020 refresh for HVWDII Measure 1 for one or more refreshes in 2022, when there will be no HIS Section O data, if doing so will allow us to consolidate changes and thus operate more efficiently.

d. Update on Transition From Hospice Compare to Care Compare and Provider Data Catalog

In September 2020, we launched *Care Compare,* a streamlined redesign of eight existing CMS healthcare compare tools available on *Medicare.gov,* including Hospice Compare. Care Compare provides a single user-friendly interface that patients and family caregivers can use to make informed

decisions about healthcare based on cost, quality of care, volume of services, and other data. With just one click, patients can find information that is easy to understand about doctors, hospitals, nursing homes, and other health care services instead of searching through multiple tools.

For the last six years, Medicare's Hospice Compare has served as the cornerstone for publicizing quality care information for patients, family caregivers, consumers, and the healthcare community. The new website builds on the *eMedicare initiative* to deliver simple tools and information to current and future Medicare beneficiaries. Drawing on lessons learned through research and stakeholder feedback, Care Compare includes features and functionalities that appeal to Hospice Compare consumers. By offering an accessible and user-friendly interface and a simple design that is optimized for mobile and tablet use, it is easier than ever to find information that is important to patients when shopping for healthcare. Enhancements for mobile use will give practical benefits like accessing the tool using a smartphone that can initiate phone calls to providers simply by clicking on the provider's phone number.

In conjunction with the Care Compare launch, we have made additional improvements to other CMS data tools, to help Medicare beneficiaries compare costs. Specifically, the *Provider Data Catalog* (PDC) better serves innovators and stakeholders who are interested in detailed CMS data and use interactive and downloadable datasets like those currently available on *data.Medicare.gov.* The PDC now makes quality datasets available through an improved Application Programming Interface (API), allowing innovators in the field to easily access and analyze the CMS publicly-reported data and make it useful for patients.

e. Update on Additional Information on Hospices for Public Reporting

In the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (83 FR 38622), we finalized plans to publicly post information from the Medicare Provider Utilization and Payment Data: Hospice Public Use File (PUF) and other publicly-available CMS data to Hospice Compare or another CMS website. Hospice PUF data are available for CY 2014 through CY 2016. Beginning with CY 2017 data, hospice PUF data are public as part of the Post-Acute Care and Hospice Provider Utilization and Payment PUF (hereafter PAC PUF). For more information, please visit the PAC PUF web page at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/PAC2017.* Both the Hospice and PAC PUFs provide information on services provided to Medicare beneficiaries by hospice providers. Specifically, they contain information on utilization, payment (Medicare payment and standard payment), submitted charges, primary diagnoses, sites of service, and beneficiary demographics organized by CCN (6-digit provider identification number) and state.

PUF data, along with clear text explaining the purpose and uses of this information and suggesting consumers discuss this information with their healthcare provider, first displayed in a consumer-friendly format on Hospice Compare in May 2019. Beginning May 2021, we will begin to display additional information from the PAC PUF on Care Compare. This additional information includes hospices' beneficiary characteristics such as the percentage of patients enrolled in Medicare Advantage. In addition, consumers will see whether a hospice provided services to Medicare Advantage enrollees or patients who have coverage under both Medicaid and Medicare, also called dual eligible patients. The data for these additional characteristics are pulled directly from the PAC PUF file and provide potential hospice service patients and family caregivers with more detail prior to selecting a hospice.

As finalized in the FY 2019 Hospice Wage Index and Payment Update final rule (83 FR 38622), we also improved access to publicly-available information about hospices' compliance with Hospice QRP requirements. Specifically, we already post the annual Hospice APU Compliant List on the *HQRP Requirements and Best Practices* web page. This document displays the CCN, name, and address of every hospice that successfully met quality reporting program requirements for the fiscal year. Hospices are only considered compliant if they meet the standards for HIS and CAHPS reporting, as codified in § 418.312. Consumers can now access the Hospice APU compliance file from Care Compare, enabling them to determine if a particular hospice is compliant with CMS' quality reporting requirements.

G. Proposal for the January 2022 HH QRP Public Reporting Display Schedule With Fewer Than Standard Number of Quarters Due to COVID–19 Public Health Emergency Exemptions

1. Background and Statutory Authority

We include this Home Health proposal in this rule because we plan to resume public reporting for the HH QRP with the January 2022 refresh of Care Compare. In order to accommodate the exception of 2020 Q1 and Q2 data, we are proposing to resume public reporting using 3 out of 4 quarters of data for the January 2022 refresh. In order to finalize this proposal in time to release the required preview report related to the refresh, which we release 3 months prior to any given refresh (October 2021), we need the rule containing this proposal to finalize by October 2021.

The HH QRP is authorized by section 1895(b)(3)(B)(v) of the Act. Section 1895(b)(3)(B)(v)(II) of the Act requires that for 2007 and subsequent years, each HHA submit to the Secretary in a form and manner, and at a time, specified by the Secretary, such data that the Secretary determines are appropriate for the measurement of health care quality. To the extent that an HHA does not submit data in accordance with this clause, the Secretary shall reduce the home health market basket percentage increase applicable to the HHA for such year by 2 percentage points. As provided at section 1895(b)(3)(B)(vi) of the Act, depending on the market basket percentage increase applicable for a particular year, the reduction of that increase by 2 percentage points for failure to comply with the requirements of the HH QRP and further reduction of the increase by the productivity adjustment (except in 2018 and 2020) described in section 1886(b)(3)(B)(xi)(II) of the Act may result in the home health market basket percentage increase being less than 0.0 percent for a year, and may result in payment rates under the Home Health PPS for a year being less than payment rates for the preceding year. For more information on the policies we have adopted for the HH QRP, we refer readers to the following rules:

- CY 2007 HH PPS final rule (71 FR 65888 through 65891).
- CY 2008 HH PPS final rule (72 FR 49861 through 49864).
- CY 2009 HH PPS update notice (73 FR 65356).
- CY 2010 HH PPS final rule (74 FR 58096 through 58098).
- CY 2011 HH PPS final rule (75 FR 70400 through 70407).
- CY 2012 HH PPS final rule (76 FR 68574).

- CY 2013 HH PPS final rule (77 FR 67092).
- CY 2014 HH PPS final rule (78 FR 72297).
- CY 2015 HH PPS final rule (79 FR 66073 through 66074).
- CY 2016 HH PPS final rule (80 FR 68690 through 68695).
- CY 2017 HH PPS final rule (81 FR 76752).
- CY 2018 HH PPS final rule (82 FR 51711 through 51712).
- CY 2019 HH PPS final rule with comment period (83 FR 56547).
- CY 2020 HH PPS final rule (84 FR 60554 through 60611).
- CY 2021 HH PPS final rule (85 FR 70326 through 70328).

2. Public Display of Home Health Quality Data for the HH QRP

Section 1895(b)(3)(B)(v)(III) of the Act requires the Secretary to establish procedures for making HH QRP data, including data submitted under sections 1899B(c)(1) and 1899B(d)(1) of the Act, available to the public. Such public display procedures must ensure that HHAs have the opportunity to review the data that will be made public with respect to each HHA prior to such data being made public. Section 1899B(g) of the Act requires that data and information regarding PAC provider performance on quality measures and resource use or other measures be made publicly available beginning not later than 2 years after the applicable specified ''application date''.

We established our HH QRP Public Display Policy in the CY 2016 HH PPS final rule (80 FR 68709 through 68710). In that final rule, we noted that the procedures for HHAs to review and correct their data on a quarterly basis is performed through CASPER along with our procedure to post the data for the public on our Care Compare website. We have communicated our public display schedule, which supports our Public Display Policy, on our websites whereby the quarters of data included are announced.

3. Proposal To Modify HH QRP Public Reporting To Address CMS' Guidance To Except Data During the COVID–19 PHE Beginning January 2022 Through July 2024

We are proposing to modify our public display schedule to display fewer quarters of data than what we previously finalized for certain HH QRP measures for the January 2022 refreshes. Under authority of section 319 of the PHS Act, the Secretary declared a PHE effective as of January 27, 2020. On March 13, 2020, the President declared a national state of emergency under the Stafford Act, effective March 1, 2020, allowing the Secretary to invoke section 1135(b) of the Act (42 U.S.C. 1320b–5) to waive or modify the requirements of titles XVIII, XIX, and XXI of the Act and regulations to the extent necessary to address the COVID–19 PHE. Many waivers and modifications were made effective as of March 1, 2020 in accordance with the President's declaration.[57]

On March 27, 2020, we sent a guidance memorandum under the subject title, ''Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies (HHAs), Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID–19'' to the MLN Connects Newsletter and Other Program-Specific Listserv Recipients,[58] hereafter referred to as the March 27, 2020 CMS Guidance Memorandum. In the March 27, 2020 CMS Guidance Memo, we granted an exception to the HH QRP reporting requirements under the HH QRP exceptions and extension requirements for Quarter 4 (Q4) 2019 (October 1, 2019 through December 31, 2019), Q1 2020 (January 1, 2020 through March 30, 2020), and Q2 2020 (April 1, 2020 through June 30, 2020). The HH QRP exception applied to the HH QRP Outcome and Assessment Information Set (OASIS)-based measures, claims-based measures, and HH CAHPS Survey. We discuss the impact to the OASIS and claims here, and discuss to the HH CAHPS further in section III.G. 4, Update on Use of Q4 2019 HH QRP Data and Data Freeze for Refreshes in 2021. For the OASIS, the exempted quarters are based upon admission and discharge assessments.

A subset of the HH QRP measures has been publicly displayed on Home Health Compare (HH Compare) since 2003. Under the current HH QRP public display policy, Home Health Compare uses 4 quarters of data to publicly display OASIS-based measures, and 4 or more quarters of data to publicly display claims-based measures. We use four rolling quarters of data to publicly display Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Survey measures on Care Compare. As of September 2020, HH QRP OASIS, claims-based, and HHCAHPS Survey measures are reported on the *www.medicare.gov's* Care Compare website. As of December 2020, the data is no longer reported on the *www.medicare.gov's* Home Health Compare website.

The exception granted under the March 27, 2020 CMS Guidance Memo impacted the HH QRP public display schedule. We will resume publicly displaying HH QRP claims-based measures in January 2022 based upon the quarters of data specified for each of the claims-based measures. Table 30 displays the original schedule for public reporting of OASIS and HHCAHPS Survey measures prior to the Q1 and Q2 2020 data impacted by the COVID–19 PHE.

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[57] Azar, A.M. (2020 March 15). *Waiver or Modification of Requirements Under Section 1135 of the Social Security Act.* Public Health Emergency. *https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx.*

[58] (2020, March 27). *Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID–19.* Centers for Medicare & Medicaid Services. *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

TABLE 30: Original Public Reporting Schedule with Refreshes

Quarter Refresh	HH Quarters in Original Schedule for Care Compare	HHCAHPS Survey Quarters in Original Schedule for Care Compare
October 2020	OASIS, ACH, & ED quality measure (QM): Q1 2019- Q4 2019 DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	Q2 2019 – Q1 2020
*January 2021	OASIS, ACH, & ED QM: Q2 2019- Q1 2020 DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	Q3 2019 – Q2 2020
*April 2021	OASIS, ACH & ED QM: Q3 2019- Q2 2020 DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	Q4 2019 – Q3 2020
*July 2021	OASIS, ACH & ED QM: Q4 2019-Q3 2020 DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	Q1 2020 – Q4 2020
*October 2021	OASIS, ACH & ED QM: Q1 2020- Q4 2020 DTC, MSPB: Q1 2019- Q4 2020 (8) PPR: Q1 2018- Q4 2020 (12)	Q2 2020 – Q1 2021
*January 2022	OASIS, ACH & ED QM: Q2 2020- Q1 2021 DTC, MSPB: Q1 2019 – Q4 2020 (8) PPR: Q1 2018 – Q4 2020 (12)	Q3 2020 – Q2 2021
†*April 2022	OASIS, ACH & ED QM: Q3 2020-Q2 2021 DTC, MSPB: Q1 2019 – Q4 2020 (8) PPR: Q1 2018 – Q4 2020 (12)	Q4 2020 - Q3 2021
†July 2022	OASIS, ACH & ED QM: Q4 2020-Q3 2021 DTC, MSPB: Q1 2019- Q4 2020 (8) PPR: Q1 2018- Q4 2020 (12)	Q1 2021 - Q4 2021
†October 2022	OASIS, ACH & ED QM: Q1 2021-Q4 2021 DTC, MSPB: Q1 2020- Q4 2021 (8) PPR: Q1 2019- Q4 2021 (12)	Q2 2021 - Q1 2022

†January 2023	OASIS, ACH & ED QM: Q2 2021-Q1 2022 DTC, MSPB: Q1 2020- Q4 2021 (8) PPR: Q1 2019- Q4 2021 (12)	Q3 2021 - Q2 2022
†April 2023	OASIS, ACH & ED QM: Q3 2021-Q2 2022 DTC, MSPB: Q1 2020- Q4 2021 (8) PPR: Q1 2019- Q4 2021 (12)	Q4 2021 - Q3 2022
†July 2023	OASIS, ACH & ED QM: Q4 2021-Q3 2022 DTC, MSPB: Q1 2020- Q4 2021 (8) PPR: Q1 2019- Q4 2021 (12)	Q1 2022-Q4 2022
††October 2023	OASIS, ACH, ED Use: Q1 2022-Q4 2022 DTC, MSPB: Q1 2021- Q4 2022 (8) PPR: Q1 2020- Q4 2022 (12)	Q2 2022 - Q1 2023
††January 2024	OASIS, ACH, ED Use: Q2 2022-Q1 2023 DTC, MSPB: Q1 2021- Q4 2022 (8) PPR: Q1 2020- Q4 2022 (12)	Q3 2022 -Q2 2023
††April 2024	OASIS, ACH, ED Use: Q3 2022-Q2 2023 DTC, MSPB: Q1 2021- Q4 2022 (8) PPR: Q1 2020- Q4 2022 (12)	Q4 2022-Q3 2023
†† July 2024	OASIS, ACH, ED Use: Q4 2022-Q3 2023 DTC, MSPB: Q1 2021- Q4 2022 (8) PPR: Q1 2020- Q4 2022 (12)	Q1 2023-Q4 2023
October 2024	OASIS, ACH, ED Use: Q1 2023-Q4 2023 DTC, MSPB: Q1 2022- Q4 2023 (8) PPR: Q1 2021- Q4 2023 (12)	Q2 2023 - Q1 2024

*Exceptions affect both OASIS and HHCAHPS Survey data for refresh; †Exceptions affect only HHCAHPS Survey measures and some claims-based measures for refresh; †† Exceptions affect only some claims-based measures.

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During the spring and summer of 2020, we conducted testing to inform decisions about publicly displaying HH QRP data for those refreshes which include data from the exception period of October 1, 2019 through June 30, 2020 (hereafter ''excepted data''). The testing helped us develop a plan for displaying HH QRP data that are as up-to-date as possible and that also meet scientifically-acceptable standards for publicly displaying those data. We believe that the plan allows us to provide consumers with helpful information on the quality of home health care, while also making the necessary adjustments to accommodate the exception granted to HHAs. The following sections provide the results of our testing for OASIS and claims and explain how we used the results to inform a proposal for accommodating excepted data in public reporting. HH CAHPS discussion is further in section III.G.4.

4. Update on Use of Q4 2019 HH QRP Data and Data Freeze for Refreshes in 2021

In the March 27, 2020 Guidance Memorandum, we stated that we should not include any PAC quality data that are greatly impacted by the exception granted in the quality reporting programs. Given the timing of the PHE onset, we determined that we would not use HH QRP OASIS, claims, or HHCAHPS data from Q1 and Q2 of 2020 for public reporting, and that we would assess the impact of the COVID–19 PHE on HH QRP data from Q4 2019. In the original schedule (Table 30), the October 2020 refresh included Q4 2019 measure based on OASIS and HHCAHPS data and is the last refresh before Q1 2020 data are included.

Before proceeding with the October 2020 refresh, we conducted testing to ensure that publicly displaying Q4 2019 data would still meet our standards despite granting an exception to HH QRP reporting requirements for Q4 2019. Specifically, we compared submission rates in Q4 2019 to average rates in other quarters to assess the extent to which HHAs had taken advantage of the exemption, and thus the extent to which data and measure scores might be affected. We observed that the quality data submission rate for Q4 2019 was in fact 0.4 percent higher than the previous calendar year (Q4 2018). We note that Q4 2019 ended before the onset of the COVID–19 pandemic in the U.S. Thus, we proceeded with including Q4 2019 data in measure calculations for the October 2020 refresh.

Because we excepted HHAs from the HH QRP reporting requirements for Q1 and Q2 2020, we did not use OASIS, claims, or HHCAHPS data from these quarters. All refreshes, during which we decided to hold this data constant, included more than 2 quarters of data that were affected by the CMS-issued COVID reporting exceptions, thus we did not have an adequate amount of data to reliably calculate and publicly display provider measures scores.

Consequently, we determined to freeze the data displayed, that is, holding data constant after the October 2020 refresh without subsequently updating the data through October 2021. We communicated this in a Public Reporting Tip Sheet, which is located at: *https://www.cms.gov/files/document/hhqrp-pr-tip-sheet081320final-cx-508.pdf.*

5. Proposal To Use the COVID–19 PHE Affected Reporting (CAR) Scenario To Publicly Display Certain HH QRP Measures (Beginning in January 2022 through July 2024) Due to the COVID–19 PHE

We are also proposing to use the CAR scenario for refreshes for January 2022 for OASIS and for refreshes from January 2022 through July 2024 for some claims-based measures. There are several forthcoming HH QRP refreshes

for which the original public reporting schedule included other quarters from the quality data submission exception. These refreshes for claims-based measures, OASIS-based measures, and for HHCAHPS Survey measures are outlined above (Table 30).

Because October 2020 refresh data will become increasingly out-of-date and thus less useful for the public, we analyzed whether it would be possible to use fewer quarters of data for one or more refreshes and thus reduce the number of refreshes that continue to display October 2020 data. Using fewer quarters of more up-to-date data requires that: (1) A sufficient percentage of HHAs would still likely have enough OASIS data to report quality measures (reportability); and (2) using fewer quarters of data to calculate measures would likely produce similar measure scores for HHAs, and thus not unfairly represent the quality of care HHAs provided during the period reported in a given refresh (reliability).

To assess these criteria, we conducted reportability and reliability analysis excluding the COVID–19 affected quarters of data in a refresh instead of the standard number of quarters of data for reporting for each HH QRP measure to model the impact of not using Q1 or Q2 2020. Specifically, we used historical data to calculate HH quality measures under two scenarios:

- Standard Public Reporting (SPR) Scenario: We used HH QRP data from CY 2017 through 2019 to build the standard reported measures, to represent as a proxy CY 2020 public reporting in the absence of the temporary exemptions from the submission of OASIS quality data, as the basis for comparing simulated alternatives. This entails using 4 quarters of CY 2019 HH QRP data to model the OASIS based measures that are normally calculated using 4 quarters of data. This also entailed using 4 quarters of HH QRP data from CY 2019 for the all-cause hospitalization and emergency department use claims-based measures, 8 quarters of HH QRP data from CY2018 and CY2019 for Medicare spending per beneficiary (MSPB) and discharge to community (DTC) claims-based measures; and or 12 quarters from January 2017 to December 2019 for the potentially preventable readmission claims-based measure.
- COVID–19 Affected Reporting (CAR) Scenario: We calculated OASIS-based measures using 3 quarters of HH QRP CY 2019 data to simulate using only Q3 2020, Q4 2020, and Q1 2021 data for public reporting. We calculated claims-based measures using HH QRP CY 2017 to 2019 data, to simulate using the most recent data while excluding the same quarters (Q1 and Q2) that are relevant from the PHE exception. We used 3 quarters of HH QRP data from CY 2019 for the all-cause hospitalization and emergency department use claims-based measures and 6 quarters of data from HH QRP CY 2018 and CY 2019 were used for both the Medicare spending per beneficiary and discharge to community claims-based measures. We used 10 quarters of HH QRP data from CY 2017 to 2019 to calculate the CAR scenario for the potentially preventable readmissions claims-based measure. For both claims and OASIS-based measures, the quarters used in our analysis were the most recently available data that exclude the same quarters (Q1 and Q2) as that are relevant from the PHE exception, and thus take seasonality into consideration.

The OASIS-based measures are based on the start of care and calculated using admission dates. Therefore, under the CAR scenario we excluded data for OASIS-based measures for HHA patient stays with admission dates in Q1 and Q2 2019. To assess performance in these scenarios, we calculated the reportability as the percent of HHAs meeting the 20-case minimum for public reporting (the public reporting threshold, or ''PRT''). We evaluated measure reliability using the Pearson and Spearman correlation coefficients, which assess the alignment of HHs measure scores between scenarios. To calculate the reliability results, we restricted the HHAs included in the SPR Scenario to those included in the CAR Scenario.

Testing results showed that using the CAR scenario would achieve scientifically acceptable quality measure scores for the HH QRP. As displayed in Table 31, the percentage of HHAs that met the public display threshold for the OASIS-based measure decreases by 5.5 percentage points or less for all but one QM, the Influenza Immunization for the Current Flu Season in the CAR scenario versus SPR scenario. CMS has traditionally used a reportability threshold of 70 percent, meaning at least 70 percent of HHAs are able to report at least 20 episodes for a given measure, as the standard to determine whether a measure should be publicly reported. By this standard, we consider a decrease of 5.5 percentage points or less scientifically acceptable. The change in reportability for the Influenza Immunization for the Current Flu Season measure is related to the seasonality of this measure, which includes cases that occur during the flu season only.

Under the CAR scenario, the January 2022 refresh data would cover Q3 and Q4 of 2020 and Q1 of 2021, which occur during the flu season. This simulation included Q2 through Q4 of 2019, which crosses the flu season. Thus, the reportability of the actual data used is likely to be better than this simulation. Therefore, in general, using CAR scenario for the OASIS and claims-based measures would achieve acceptable reportability for the HH QRP measures. Testing also yielded correlation coefficients above 0.85, indicating a high degree of agreement between HH measure scores when using the CAR scenario or the SPR scenario.

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TABLE 31: HH QRP Measure Results Under the SPR and CAR Scenarios

	Reportability			Reliability	
Measure Reference Name	**% providers meeting PRT (Standard Public Reporting, SPR Scenario)**	**% providers meeting PRT (COVID-19 Affected Reporting, CAR Scenario)**	**Change in % Providers meeting PRT**	**Pearson Correlation**	**Spearman Correlation**
Application of Percent of Long Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF 2631)	86.2	81.9%	4.3%	.97	.91
Changes in Skin Integrity Post-Acute Care Pressure	80.9%	75.9%	5%	.85	.87

	Reportability			Reliability	
Measure Reference Name	**% providers meeting PRT (Standard Public Reporting, SPR Scenario)**	**% providers meeting PRT (COVID-19 Affected Reporting, CAR Scenario)**	**Change in % Providers meeting PRT**	**Pearson Correlation**	**Spearman Correlation**
Ulcers/Injuries					
Drug Regimen Review	86.2%	81.9%	4.3%	.99	.96
Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)	86.1%	81.7%	4.4%	.89	.88
Influenza Immunization Received for Current Flu Season	81.9%	70.7%	11.2%	.92	.90
Timely Initiation of Care (NQF #0526)	86.2%	81.9%	4.3%	.97	.95
Improvement in Ambulation (NQF #0167)	80.4%	75.6%	4.8%	.98	.97
Improvement in Bed Transfer (NQF 175)	80.1%	75.2%	4.9%	.98	.97
Improvement in Bathing (NQF #0174)	80.8%	75.7%	5.1%	.98	.97
Improvement in Dyspnea	79.1%	73.6%	5.5%	.98	.97
Improvement in Management of Oral Medications (NQF #0176)	79.1%	73.8%	5.3%	.98	.97
Discharge to Community (DTC) (NQF 3477)	86.5	81.7	4.8%	.95	.96
Medicare Spending per Beneficiary (MSPB)	91.3	89.8	1.5%	.94	.94
Acute care Hospitalization (AH) (NQF #0171)	80.9	75.8	5.1%	.88	.87
Emergency Department Use (EDU) (NQF # 0173)	80.9	75.8	5.1%	.91	.90

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We are proposing to use the CAR scenario for the last of the refreshes affecting OASIS-based measures, which will occur in January 2022. We are also proposing to use the CAR scenario for refreshes from January 2022 through July 2024 for some claims-based measures.

Our proposal of the CAR scenario for the January 2022 refresh would allow us to begin displaying recent data in January 2022, rather than continue displaying October 2020 data (Q1 2019

through Q4 2019). We believe that updating the data in January 2022 by more than a year relative to the October 2020 freeze data can assist the public by providing more relevant quality data and allow CMS to display more recent HHA performance. Similarly, using fewer than standard numbers of quarters for claims-based measures that typically use eight or twelve months of data for reporting between January 2022 and July 2024 will allow us to begin providing more relevant data sooner. Our testing results indicate we can achieve these positive impacts while maintaining high standards for reportability and reliability. Table 32 and Table 33 summarize the comparison between the original schedule for public reporting with the revised schedule (that is, frozen data) and also with the proposed public display schedule under the CAR scenario (that is, using 3 quarters in the January 2022 refresh), for OASIS- and claims-based measures respectively.

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TABLE 32: Original, Revised, and Proposed Schedule for Refreshes Affected by COVID-19 PHE Exceptions for HH OASIS-based QMs

Quarter Refresh	OASIS Quarters in Original Schedule for Care Compare (number of quarters)	OASIS Quarters in revised/proposed Schedule for Care Compare (number of quarters)
October 2020	Q1 2019- Q4 2019 (4)	Q1 2019- Q4 2019 (4)
January 2021	Q2 2019- Q1 2020 (4)	Q1 2019- Q4 2019 (4)
April 2021	Q3 2019-Q2 2020 (4)	Q1 2019- Q4 2019 (4)
July 2021	Q4 2019- Q3 2020 (4)	Q1 2019- Q4 2019 (4)
October 2021	Q1 2020- Q4 2020 (4)	Q1 2019- Q4 2019 (4)
January 2022*	Q2 2020-Q1 2021 (4)	Q3 2020-Q1 2021 (3)

Note: The shades cells represent data frozen due to PHE related to COVID-19.
* OASIS data with 3 versus 4 quarters of data

TABLE 33: Original, Revised, and Example Schedule for Refreshes Affected by COVID-19 PHE Exceptions for HH Claims-based QMs

Quarter Refresh *Dates are for example only---Actual Dates will be provided sub-regulatory	Claims-based Quarters in Original Schedule for Care Compare (number of quarters)	Claims-based Quarters in revised/proposed Schedule for Care Compare (number of quarters) *Quarters are for example only---Actual Quarters will be provided sub-regulatory
October 2020	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
January 2021	ACH, ED Use: Q2 2019- Q1 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
April 2021	ACH, ED Use: Q3 2019-Q2 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
July 2021	ACH, ED Use: Q4 2019- Q3 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
October 2021	ACH, ED Use: Q1 2020- Q4 2020 (4) DTC, MSPB: Q1 2019- Q4 2020 (8) PPR: Q1 2018- Q4 2020 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
January 2022*	ACH, ED Use: Q2 2020-Q1 2021 (4) DTC, MSPB: Q1 2019- Q4 2020 (8) PPR: Q1 2018- Q4 2020 (12)	ACH, ED Use: Q3 2020-Q1 2021 (3) DTC, MSPB: Q1 2019- Q4 2019; Q3 2020 –Q4 2020 (6) PPR: Q1 2018-Q4 2019 Q3 2020 – Q4 2020 (10)
October 2022*	ACH, ED Use: Q1 2021-Q4 2021 (4) DTC, MSPB: Q1 2020- Q4 2021 (8) PPR: Q1 2019- Q4 2021 (12)	ACH, ED Use: Q1 2021-Q4 2021 (4) DTC, MSPB: Q3 2020 –Q4 2020 (6) PPR: Q1 2019-Q4 2019 Q3 2020 – Q4 2021 (10)
October 2023*	ACH, ED Use: Q1 2022-Q4 2022 (4) DTC, MSPB: Q1 2021- Q4 2022 (8) PPR: Q1 2020- Q4 2022 (12)	ACH, ED Use: Q1 2022-Q4 2022 (4) DTC, MSPB: Q1 2021- Q4 2022; (8) PPR: Q3 2020-Q4 2020 Q1 2021 – Q4 2022 (10)
October 2024†	ACH, ED Use: Q1 2023-Q4 2023 (4) DTC, MSPB: Q1 2022- Q4 2023 (8) PPR: Q1 2021- Q4 2023 (12)	ACH, ED Use: Q1 2023-Q4 2023 (4) DTC, MSPB: Q1 2022- Q4 2023 (8) PPR: Q1 2021- Q4 2023 (12)

Note: The shades cells represent data frozen due to PHE related to COVID-19. DTC, MSPB and PPR measures are updated annually in October.

* Refreshes with few quarters of certain claims data.

† Refresh with the original public reporting schedule resuming for claims data.

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We are soliciting public comments on the proposal to use the CAR scenario to publicly report HH OASIS in January 2022 and claims-based measures beginning with the January 2022 through July 2024 refreshes.

6. Update to the Public Display of HHCAHPS Measures Due to the COVID–19 PHE Exception

Since April 2012, we have publicly displayed four quarters of HHCAHPS data every quarter, in the months of January, April, July, and October. The COVID–19 PHE Exception applied to Q1 and Q2 of 2020. Those excepted quarters cannot be publicly displayed and resulted in the freezing of the public display using Q1 2019 through Q4 2019 data for the refreshes that would have occurred from October 2020 through October 2021, as shown in Table 34. Beginning with January 2022, we will resume reporting four quarters of HHCAHPS data. The data for the January 2022 refresh are Q3 2020 through Q2 2021. These are the same quarters that would have been publicly

displayed despite the COVID–19 PHE.
Table 34 summarizes this discussion.

TABLE 34: HHCAHPS Public Reporting Quarters During and After the Freeze

Refresh	Publicly Reported Quarters
Freeze:	Q1 2019 - Q4 2019
October 2020-October 2021*	Q1 2019 – Q4 2019
January 2022**	Q3 2020-Q2 2021
April 2022	Q4 2020-Q3 2021
July 2022	Q1 2021-Q4 2021
October 2022	Q2 2021-Q1 2022
January 2023	Q3 2021-Q2 2022
April 2023	Q4 2021-Q3 2022
July 2023	Q1 2022-Q4 2022
*The grey shading refers to the frozen quarters.	
**Resume rolling of most recent four rolling quarters of data. These are the same rolling quarters that would have displayed regardless of the COVID-19 PHE.	

IV. Requests for Information

A. Fast Healthcare Interoperability Resources (FHIR) in Support of Digital Quality Measurement in Post-Acute Care Quality Reporting Programs—Request for Information

1. Background

A goal of the HQRP is to improve the quality of health care for beneficiaries through measurement, transparency, and public reporting of data. The HQRP contributes to improvements in health care, enhancing patient outcomes, and informing consumer choice. In October 2017, we launched the Meaningful Measures Framework. This framework captures our vision to address health care quality priorities and gaps, including emphasizing digital quality measurement (dQM), 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.[59] There is a need to streamline our approach to data collection, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, improvement, and learning.

In alignment with the Meaningful Measure 2.0, we are seeking feedback on our future plans to define digital quality measures for the HQRP. We also are seeking feedback on the potential use of Fast Healthcare Interoperable Resources (FHIR) for dQMs within the HQRP aligning where possible with other quality programs. FHIR is an open source standards framework (in both commercial and government settings) created by Health Level Seven International (HL7®) that establishes a common language and process for all health information technology.

2. Definition of Digital Quality Measures

We are considering adopting a standardized definition of Digital Quality Measures (dQMs) in alignment across QRPs. We are considering in the future to propose the adoption within the HQRP the following definition: Digital Quality Measures (dQMs) are quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable

[59] Meaningful Measures 2.0: Moving from Measure Reduction to Modernization. Available at: *https://www.cms.gov/meaningful-measures-20-moving-measure-reduction-modernization.*

systems.[60] A dQM includes software that processes digital data to produce a measure score or measure scores. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, electronic health records (EHRs), instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data), health information exchanges (HIEs) or registries, and other sources. As an example, the quality measures calculated from patient assessment data submitted electronically to CMS would be considered digital quality measures.

3. Use of FHIR for Future dQMs in HQRP

Over the past two years in other programs, we have focused on opportunities to streamline and modernize quality data collection and reporting processes, such as exploring HL7® FHIR® (*http://hl7.org/fhir*) for quality reporting programs. One of the first areas CMS has identified relative to improving our digital strategy is through the use of FHIR-based standards to exchange clinical information through application programming interfaces (APIs), allowing clinicians to digitally submit quality information one time that can then be used in many ways. We believe that in the future proposing such a standard within the HQRP could potentially enable collaboration and information sharing, which is essential for delivering high-quality care and better outcomes at a lower cost.

We are currently evaluating the use of FHIR based APIs to access assessment data collected and maintained through the Quality Improvement and Evaluation System (QIES) and internet QIES (iQIES) health information systems and are working with healthcare standards organizations to assure that their evolving standards fully support our assessment instrument content. Further, as more hospice providers are adopting EHRs including hospices, we are evaluating using the FHIR interfaces for accessing patient data (including standard assessments) directly from hospice EHRs. Accessing data in this manner could also enable the exchange of data for purposes beyond data reporting to CMS, such as care coordination further increasing the value of EHR investments across the healthcare continuum. Once providers map their EHR data to a FHIR API in standard FHIR formats it could be possible to send and receive the data needed for measures and other uses from their EHRs through FHIR APIs.

4. Future Alignment of Measures Across Reporting Programs, Federal and State Agencies, and the Private Sector

We are committed to using policy levers and working with stakeholders to achieve interoperable data exchange and to transition to full digital quality measurement in our quality programs. We are considering the future potential development and staged implementation of a cohesive portfolio of dQMs across our regulated programs, including HQRP, agencies, and private payers. This cohesive portfolio would require, where possible, alignment of: (1) Measure concepts and specifications including narrative statements, measure logic, and value sets, and (2) the individual data elements used to build these measure specifications and calculate the measures. Further, the required data elements would be limited to standardized, interoperable elements to the fullest extent possible; hence, part of the alignment strategy will be the consideration and advancement of data standards and implementation guides for key data elements. We would coordinate closely with quality measure developers, Federal and state agencies, and private payers to develop and to maintain a cohesive dQM portfolio that meets our programmatic requirements and that fully aligns across Federal and state agencies and payers to the extent possible.

We intend this coordination to be ongoing and allow for continuous refinement to ensure quality measures remain aligned with evolving healthcare practices and priorities (for example, patient reported outcomes (PROs), disparities, care coordination), and track with the transformation of data collection. This includes conformance with standards and health IT module updates, future adoption of technologies incorporated within the ONC Health IT Certification Program and may also include standards adopted by ONC (for example, standards-based APIs). The coordination would build on the principles outlined in HHS' Nation Health Quality Roadmap.[61]

It would focus on the quality domains of safety, timeliness, efficiency, effectiveness, equitability, and patient-centeredness. It would leverage several existing Federal and public-private efforts including our Meaningful Measures 2.0 Framework; the Federal Electronic Health Record Modernization (DoD/VA); the Core Quality Measure Collaborative, which convenes stakeholders from America's Health Insurance Plans (AHIP), CMS, NQF, provider organizations, private payers, and consumers and develops consensus on quality measures for provider specialties; and the NQF-convened Measure Applications Partnership (MAP), which recommends measures for use in public payment and reporting programs. We would coordinate with HL7's ongoing work to advance FHIR resources in critical areas to support patient care and measurement such as social determinants of health. Through this coordination, we would identify which existing measures could be used or evolved to be used as dQMs, in recognition of current healthcare practice and priorities.

This multi-stakeholder, joint Federal, state, and industry effort, made possible and enabled by the pending advances towards interoperability, would yield a significantly improved quality measurement enterprise. The success of the dQM portfolio would be enhanced by the degree to which the measures achieve our programmatic requirements as well as the requirements of other agencies and payers.

5. Solicitation of Comments

We seek input on the following steps that would enable transformation of CMS' quality measurement enterprise to be fully digital:

a. What EHR/IT systems do you use and do you participate in a health information exchange (HIE)?

b. How do you currently share information with other providers and are there specific industry best practices for integrating SDOH screening into EHR's?

c. What ways could we incentivize or reward innovative uses of health information technology (IT) that could reduce burden for post-acute care settings, including but not limited to hospices?

d. What additional resources or tools would post-acute care settings, including but not limited to hospices and health IT vendors find helpful to support testing, implementation, collection, and reporting of all measures using FHIR standards via secure APIs to reinforce the sharing of patient health information between care settings?

e. Would vendors, including those that service post-acute care settings, including but not limited to hospices, be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that

[60] Definition taken from the CMS Quality Conference 2021.

[61] Department of Health and Human Services. National Health Quality Roadmap. May 15, 2020. Available at: *https://www.hhs.gov/sites/default/files/national-health-quality-roadmap.pdf.*

would align standards for quality measure data collection across care settings to improve care coordination, such as sharing patient data via secure FHIR API as the basis for calculating and reporting digital measures?

f. What could be the potential use of FHIR dQMs that could be adopted across all QRPs?

We plan to continue working with other agencies and stakeholders to coordinate and to inform our transformation to dQMs leveraging health IT standards. While we will not be responding to specific comments submitted in response to this Request for Information in the FY 2022 Hospice final rule, we will actively consider all input as we develop future regulatory proposals or future sub-regulatory policy guidance. Any updates to specific program requirements related to quality measurement and reporting provisions would be addressed through separate and future notice- and-comment rulemaking, as necessary.

B. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs—Request for Information

1. Background

Significant and persistent inequities in health outcomes exist in the United States. In recognition of persistent health disparities and the importance of closing the health equity gap, we request 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 patients. Belonging to a racial or ethnic minority group; living with a disability; being a member of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community; or being near or below the poverty level, is often associated with worse health outcomes.[62] [63] [64] [65] [66] [67] [68] [69] Such disparities in health outcomes are the result of number of factors, but importantly for CMS programs, although not the sole determinant, poor access and provision of lower quality health care contribute to health disparities. For instance, numerous studies have shown that among Medicare beneficiaries, racial and ethnic minority individuals often receive lower quality of care, report lower experiences of care, and experience more frequent hospital readmissions and operative complications.[70] [71] [72] [73] [74] [75] Readmission rates for common conditions in the Hospital Readmissions Reduction Program are higher for black Medicare beneficiaries and higher for Hispanic Medicare beneficiaries with Congestive Heart Failure and Acute Myocardial Infarction.[76] [77] [78] [79] [80] Studies have also shown that African Americans are significantly more likely than white Americans to die prematurely from heart disease and stroke.[81] The COVID–19 pandemic has further illustrated many of these longstanding health inequities with higher rates of infection, hospitalization, and mortality among black, Latino, and Indigenous and Native American persons relative to white persons.[82] [83] As noted by the Centers for Disease Control ''long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID–19''.[84] One important strategy for addressing these important inequities is by improving data collection to allow for better measurement and reporting on equity across our programs and policies.

We are committed to achieving equity in health care outcomes for our beneficiaries by supporting providers in quality improvement activities to reduce health inequities, enabling beneficiaries to make more informed decisions, and promoting provider accountability for health care disparities.[85] [86] For the purposes of this rule, we are using a definition of equity established in Executive Order 13985, as ''the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely

[62] Joynt KE, Orav E, Jha AK. Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA. 2011; 305(7):675–681.

[63] Lindenauer PK, Lagu T, Rothberg MB, et al. Income Inequality and 30 Day Outcomes After Acute Myocardial Infarction, Heart Failure, and Pneumonia: Retrospective Cohort Study. British Medical Journal. 2013; 346.

[64] Trivedi AN, Nsa W, Hausmann LRM, et al. Quality and Equity of Care in U.S. Hospitals. New England Journal of Medicine. 2014; 371(24):2298–2308.

[65] Polyakova, M., et al. Racial Disparities In Excess All-Cause Mortality During The Early COVID–19 Pandemic Varied Substantially Across States. Health Affairs. 2021; 40(2): 307–316.

[66] Rural Health Research Gateway. Rural Communities: Age, Income, and Health Status. Rural Health Research Recap. November 2018.

[67] *https://www.minorityhealth.hhs.gov/assets/PDF/Update_HHS_Disparities_Dept-FY2020.pdf.*

[68] *www.cdc.gov/mmwr/volumes/70/wr/mm7005a1.htm.*

[69] Poteat TC, Reisner SL, Miller M, Wirtz AL. COVID–19 Vulnerability of Transgender Women With and Without HIV Infection in the Eastern and Southern U.S. Preprint. *medRxiv.* 2020;2020.07.21.20159327. Published 2020 Jul 24. doi:10.1101/2020.07.21.20159327.

[70] Martino, SC, Elliott, MN, Dembosky, JW, Hambarsoomian, K, Burkhart, Q, Klein, DJ, Gildner, J, and Haviland, AM. Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage. Baltimore, MD: CMS Office of Minority Health. 2020.

[71] Guide to Reducing Disparities in Readmissions. CMS Office of Minority Health. Revised August 2018. Available at: *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf.*

[72] Singh JA, Lu X, Rosenthal GE, Ibrahim S, Cram P. Racial disparities in knee and hip total joint arthroplasty: An 18-year analysis of national Medicare data. Ann Rheum Dis. 2014 Dec;73(12):2107–15.

[73] Rivera-Hernandez M, Rahman M, Mor V, Trivedi AN. Racial Disparities in Readmission Rates among Patients Discharged to Skilled Nursing Facilities. J Am Geriatr Soc. 2019 Aug;67(8):1672–1679.

[74] Joynt KE, Orav E, Jha AK. Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA. 2011;305(7):675–681.

[75] Tsai TC, Orav EJ, Joynt KE. Disparities in surgical 30-day readmission rates for Medicare beneficiaries by race and site of care. Ann Surg. Jun 2014;259(6):1086–1090.

[76] Rodriguez F, Joynt KE, Lopez L, Saldana F, Jha AK. Readmission rates for Hispanic Medicare beneficiaries with heart failure and acute myocardial infarction. Am Heart J. Aug 2011;162(2):254–261 e253.

[77] Centers for Medicare and Medicaid Services. Medicare Hospital Quality Chartbook: Performance Report on Outcome Measures; 2014.

[78] Guide to Reducing Disparities in Readmissions. CMS Office of Minority Health. Revised August 2018. Available at: *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf.*

[79] Prieto-Centurion V, Gussin HA, Rolle AJ, Krishnan JA. Chronic obstructive pulmonary disease readmissions at minority-serving institutions. Ann Am Thorac Soc. Dec 2013;10(6):680–684.

[80] Joynt KE, Orav E, Jha AK. Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA. 2011;305(7):675–681.

[81] HHS. Heart disease and African Americans. (March 29, 2021). *https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19.*

[82] *https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf.*

[83] Ochieng N, Cubanski J, Neuman T, Artiga S, and Damico A. Racial and Ethnic Health Inequities and Medicare. Kaiser Family Foundation. Februray 2021. Available at: *https://www.kff.org/medicare/report/racial-and-ethnic-health-inequities-and-medicare/.*

[84] *https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.*

[85] *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf.*

[86] Report to Congress: Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 Strategic Plan for Accessing Race and Ethnicity Data. January 5, 2017. Available at *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Research-Reports-2017-Report-to-Congress-IMPACT-ACT-of-2014.pdf.*

affected by persistent poverty or inequality.'' [87] We note that this definition was recently established by the current administration, and provides a useful, common definition for equity across different areas of government, although numerous other definitions of equity exist.

Our ongoing commitment to closing the equity gap in CMS quality programs is demonstrated by a portfolio of programs aimed at making information on the quality of health care providers and services, including disparities, more transparent to consumers and providers. The CMS Equity Plan for Improving Quality in Medicare aims to support Quality Improvement Networks and Quality Improvement Organizations (QIN–QIOs); Federal, state, local, and tribal organizations; providers; researchers; policymakers; beneficiaries and their families; and other stakeholders in activities to achieve health equity. The CMS Equity Plan includes three core elements: (1) Increasing understanding and awareness of disparities; (2) developing and disseminating solutions to achieve health equity; and (3) implementing sustainable actions to achieve health equity.[88] The CMS Quality Strategy and Meaningful Measures Framework [89] include elimination of racial and ethnic disparities as a fundamental principle. Our ongoing commitment to closing the health equity gap in the HQRP is demonstrated by the sharing of information from the Medicare PAC PUF on Care Compare and seeking to adopt through future rulemaking aspects of the standardized patient assessment data elements (SPADEs) that apply to hospice which include several social determinants of health (SDOH).

We continue to work with Federal and private partners to better collect and leverage data on social risk to improve our understanding of how these factors can be better measured in order to close the health equity gap. Among other things, we have developed an Inventory of Resources for Standardized Demographic and Language Data Collection [90] and supported collection of specialized International Classification of Disease, 10th Edition, Clinical Modification (ICD–10–CM) codes for describing the socioeconomic, cultural, and environmental determinants of health. We continue to work to improve our understanding of this important issue and to identify policy solutions that achieve the goals of attaining health equity for all patients.

2. Solicitation of Public Comment

While hospice is not included in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (Pub. L. 113–185), we look at measures adopted based on that Act, like SPADES and if aspects apply to hospice then we would consider including it in the HQRP. This helps with continuity of care since patients may transition from different PAC settings to hospice and it would address a gap in hospice care. We are 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. Any potential health equity data collection or measure reporting within a CMS program that might result from public comments received in response to this solicitation would be addressed through a separate notice- and-comment rulemaking in the future.

Specifically, we are inviting public comment on the following:

- Recommendations for quality measures, or measurement domains that address health equity, for use in the HQRP.
- Suggested parts of SDOH SPADEs adoption that could apply to hospice in alignment with national data collection and interoperable exchange standards. This could include collecting information on certain SDOH, including race, ethnicity, preferred language, interpreter services, health literacy, transportation and social isolation. CMS is seeking guidance on any additional items, including SPADEs that could be used to assess health equity in the care of hospice patients, for use in the HQRP.
- Ways CMS can promote health equity in outcomes among hospice patients. We are also interested in feedback regarding whether including facility-level quality measure results stratified by social risk factors and social determinants of health (for example, dual eligibility for Medicare and Medicaid, race) in confidential feedback reports could allow facilities to identify gaps in the quality of care they provide. (For example, methods similar or analogous to the *CMS Disparity Methods* [91] which provide hospital-level confidential results stratified by dual eligibility for condition-specific readmission measures currently included in the Hospital Readmission Reduction Program (84 FR 42496 through 42500)).
- Methods that commenters or their organizations use in employing data to reduce disparities and improve patient outcomes, including the source(s) of data used, as appropriate.
- Given the importance of structured data and health IT standards for the capture, use, and exchange of relevant health data for improving health equity, the existing challenges providers' encounter for effective capture, use, and exchange of health information, such as data on race, ethnicity, and other social determinants of health, to support care delivery and decision making.

While we will not be responding to specific comments submitted in response to this Request for Information in the FY 2022 Hospice Wage Index final rule, we intend to use this input to inform future policy development. We look forward to receiving feedback on these topics, and note for readers that responses to the RFI will not directly impact payment decisions. We also note our intention for an additional RFI or rulemaking on this topic in the future. We look forward to receiving feedback on these topics, and note for readers that responses to the RFI should focus on how they could be applied to the quality reporting program requirements.

V. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care and patient access to their health information. To further interoperability in post-acute care settings, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) participate in the Post-Acute Care Interoperability Workgroup (PACIO) (*https://pacioproject.org/*) to facilitate collaboration with industry stakeholders to develop Fast Healthcare Interoperability Resources (FHIR)

[87] *https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-Federal-government.*

[88] Centers for Medicare & Medicaid Services Office of Minority Health. The CMS Equity Plan for Improving Quality in Medicare. *https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf.*

[89] *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.*

[90] Centers for Medicare and Medicaid Services. Building an Organizational Response to Health Disparities Inventory of Resources for Standardized Demographic and Language Data Collection. 2020. *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Collection-Resources.pdf.*

[91] *https://qualitynet.cms.gov/inpatient/measures/disparity-methods/methodology.*

standards. These standards could support the exchange and reuse of patient assessment data derived from the minimum data set (MDS), inpatient rehabilitation facility patient assessment instrument (IRF–PAI), long term care hospital continuity assessment record and evaluation (LCDS), outcome and assessment information set (OASIS), and other sources, including HOPE if implemented in HQRP through future rulemaking. The PACIO Project has focused on FHIR implementation guides for functional status, cognitive status and new use cases on advance directives and speech, and language pathology. We encourage PAC provider and health IT vendor participation as these efforts advance.

The CMS Data Element Library (DEL) continues to be updated and serves as the authoritative resource for PAC assessment data elements and their associated mappings to health IT standards such as Logical Observation Identifiers Names and Codes and Systematized Nomenclature of Medicine. The DEL furthers CMS' goal of data standardization and interoperability. These interoperable data elements can reduce provider burden by allowing the use and exchange of healthcare data; supporting provider exchange of electronic health information for care coordination, person-centered care; and supporting real-time, data driven, clinical decision making. Standards in the Data Element Library (*https://del.cms.gov/DELWeb/pubHome*) can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2021 ISA is available at *https://www.healthit.gov/isa.*

The 21st Century Cures Act (Cures Act) (Pub. L. 114–255, enacted December 13, 2016) requires HHS to take new steps to enable the electronic sharing of health information ensuring interoperability for providers and settings across the care continuum. The Cures Act includes a trusted exchange framework and common agreement (TEFCA) provision [92] that will enable the nationwide exchange of electronic health information across health information networks and provide an important way to enable bi-directional health information exchange in the future. For more information on current developments related to TEFCA, we refer readers to *https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement* and *https://rce.sequoiaproject.org/.*

On May 1, 2020, ONC published a final rule in the **Federal Register** entitled ''21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program'' (85 FR 25642) that established policies related to information blocking as authorized under section 4004 of the 21st Century Cures Act. Information blocking is generally defined as a practice by a health IT developer of certified health IT, health information network, health information exchange, or health care provider that, except as required by law or specified by the Secretary of HHS as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information. The definition of information blocking includes a knowledge standard, which is different for health care providers than for health IT developers of certified health IT and health information networks or health information exchanges. A healthcare provider must know that the practice is unreasonable as well as likely to interfere with access, exchange, or use of electronic health information. To deter information blocking, health IT developers of certified health IT, health information networks and health information exchanges whom the HHS Inspector General determines, following an investigation, have committed information blocking, are subject to civil monetary penalties of up to $1 million per violation. Appropriate disincentives for health care providers are expected to be established by the Secretary through future rulemaking. Stakeholders can learn more about information blocking at *https://www.healthit.gov/curesrule/final-rule-policy/information-blocking.* ONC has posted information resources including fact sheets (*https://www.healthit.gov/curesrule/resources/fact-sheets*), frequently asked questions (*https://www.healthit.gov/curesrule/resources/information-blocking-faqs*), and recorded webinars (*https://www.healthit.gov/curesrule/resources/webinars*).

We invite providers to learn more about these important developments and how they could affect hospices.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

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

A. ICRs Regarding Hospice QRP

The HQRP proposals would not change provider burden or costs.

- For the proposal to remove the 7 HIS measures from the HQRP, we do not propose any changes to the requirement to submit the HIS admission assessment since we continue to collect the data for these 7 HIS measures in order to calculate the more broadly applicable NQF # 3235, the Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment Measure at Admission.
- The proposal to add the HCI also would not change provider burden or costs since it is a claims-based measure that CMS calculates from the Medicare claims data.
- Likewise, the proposal to publicly report the claims-based HVLDL quality measure would not result in reduced provider burden and related costs. The reduction in provider burden and costs occurred when we replaced the HIS-based HVWDII quality measure via the HIS–PRA package that OMB approved on February 16, 2021 (OMB Control Number: 0938–1153, CMS–10390).
- Finally, the Home Health Rider proposal would not change provider burden or costs since it only affects the number of quarters used in the calculation of certain claims-based measures for the public display for certain refresh cycles.

B. ICRs Regarding Hospice CoPs

We are proposing to revise the provisions at § 418.76(c)(1) that requires the hospice aide to be evaluated by observing an aide's performance of the task with a patient. This proposed revision is subject to the PRA; however, the information collection burden associated with the existing requirements at § 418.76(c)(1) are

[92] ONC, *Draft 2 Trusted Exchange Framework and Common Agreement, https://www.healthit.gov/sites/default/files/page/2019-04/FINALTEFCAQTF41719508version.pdf.*

accounted for under the information collection request currently approved OMB control number 0938–1067. The proposed revision's addition of the use of a ''pseudo patient'' allow for greater flexibility and may minimally reduce burden on the hospice. We request public comment on our determination that the time and effort necessary to comply with implementing the use of the pseudo-patient for hospice aide training at § 418.76(c)(1), may reduce burden on the provider.

We are also proposing to revise the provisions at § 418.76(h)(1)(iii) to state that if an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation related to the deficient and related skill(s) in accordance with § 418.76(c). We believe this could increase the speed with which hospices perform competency testing and could allow new aides to begin serving patients more quickly as these proposed changes will allow the hospice to focus on specific aide skills when a skill deficiency is assessed. In accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), we believe that both the existing requirements and the proposed revisions to the requirements at § 418.76(h) are exempt from the PRA. We believe competency evaluations are a usual and customary business practice and we state as such in the information collection request associated with the Hospice Conditions of Participation (0938–1067). Therefore, we are not proposing to seek PRA approval for any information collection or recordkeeping activities that may be conducted in connection with the proposed revisions to § 418.76(h), but we request public comment on our determination that the time and effort necessary to comply with these evaluation requirements is usual and customary, and would be incurred by hospice staff even absent this regulatory requirement.

C. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB.

We invite public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS–1754–P) and, where applicable, the preamble section, and the ICR section. See this rule's **DATES** and **ADDRESSES** sections for the comment due date and for additional instructions and OMB control number 0938–1153 (CMS–10390) or OMB control number 0938–1067 (CMS–10277).

VII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VIII. Regulatory Impact Analysis

A. Statement of Need

This proposed rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used MSAs, as well as any changes to the methodology for determining the per diem payment rates. This proposed rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2022 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

B. Overall Impacts

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an estimated increase of $530 million in payments to hospices, resulting from the hospice payment update percentage of 2.3 percent for FY 2022. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2021 to FY 2022. Using the most recent complete data available at the time of rulemaking, in this case FY 2020 hospice claims data as of January 15, 2021, we apply the current FY 2021 wage index with the current labor shares. Using the same FY 2020 data, we apply the FY 2022 wage index and the current labor share values to simulate FY 2022 payments. We then apply a budget neutrality adjustment so that the aggregate simulated payments do not increase or decrease due to changes in the wage index. Then, using the same FY 2020 data, we apply the FY 2022 wage index and the current labor share values to simulate FY 2022 payments and compare simulated payments using the FY 2022 wage index and the proposed revised labor shares. We then apply a budget neutrality adjustment so that the aggregate simulated payments do not increase or decrease due to changes in the labor share values.

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

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with

economically significant effects ($100 million or more in any 1 year). We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that, to the best of our ability presents the costs and benefits of the rulemaking.

C. Anticipated Effects

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than $8.0 million to $41.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. The Department of Health and Human Services practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The effect of the FY 2022 hospice payment update percentage results in an overall increase in estimated hospice payments of 2.3 percent, or $530 million. The distributional effects of the proposed FY 2022 hospice wage index do not result in a greater than 5 percent of hospices experiencing decreases in payments of 3 percent or more of total revenue. Therefore, the Secretary has determined that this rule will not create a significant economic impact on a substantial number of small entities. In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a MSA and has fewer than 100 beds. This rule will only affect hospices. Therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals (see table 34).

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. The 2021 UMRA threshold is $158 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $158 million or more.

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

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

Using the wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11–9111); we estimate that the cost of reviewing this rule is $114.24 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). This proposed rule consists of approximately 55,000 words. Assuming an average reading speed of 250 words per minute, it would take approximately 1.83 hours for the staff to review half of it. For each hospice that reviews the rule, the estimated cost is $209.06 (1.83 hour × $114.24). Therefore, we estimate that the total cost of reviewing this regulation is $11,080.18 ($209.06 × 53 reviewers).

D. Detailed Economic Analysis

1. Proposed Hospice Payment Update for FY 2022

The FY 2022 hospice payment impacts appear in Table 34. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size), and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows the effect of using the FY 2022 updated wage index data. This represents the effect of moving from the FY 2021 hospice wage index to the FY 2022 hospice wage index. The fourth column shows the effect of the proposed rebased labor shares. The aggregate impact of the changes in column three and four is zero percent, due to the hospice wage index standardization factor and the labor share standardization factor. However, there are distributional effects of the FY 2022 hospice wage index. The fifth column shows the effect of the hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act, and is consistent for all providers. The 2.3 hospice payment update percentage is based on the 2.5 percent inpatient hospital market basket update, reduced by a 0.2 percentage point productivity adjustment. The sixth column shows the effect of all the proposed changes on FY 2022 hospice payments. It is projected aggregate payments would increase by 2.3 percent; assuming hospices do not change their billing practices. As illustrated in Table 35, the combined effects of all the proposals vary by specific types of providers and by location.

In addition, we are providing a provider-specific impact analysis file, which is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices.html.* We note that simulated payments are based on utilization in FY 2020 as seen on Medicare hospice claims (accessed from the CCW in January of 2021) and only include payments related to the level of care and do not include payments related to the service intensity add-on.

As illustrated in Table 35, the combined effects of all the proposals vary by specific types of providers and by location.

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TABLE 35: Projected Impact to Hospices for FY 2022

Hospice Subgroup	Hospices	FY 2022 Updated Wage Data	FY 2022 Labor Share	FY 2022 Hospice Payment Update (%)	Overall Total Impact for FY 2022
All Hospices	4,957	0.0%	0.0%	2.3%	2.3%
Hospice Type and Control					
Freestanding/Non-Profit	600	0.0%	-0.1%	2.3%	2.2%
Freestanding/For-Profit	3,224	0.0%	0.0%	2.3%	2.3%
Freestanding/Government	40	0.2%	-0.1%	2.3%	2.4%
Freestanding/Other	365	-0.3%	0.1%	2.3%	2.1%
Facility/HHA Based/Non-Profit	366	0.0%	0.0%	2.3%	2.3%
Facility/HHA Based/For-Profit	193	0.1%	0.2%	2.3%	2.6%
Facility/HHA Based/Government	90	0.2%	0.5%	2.3%	3.0%
Facility/HHA Based/Other	79	0.4%	-0.2%	2.3%	2.5%
Subtotal: Freestanding Facility Type	4,229	0.0%	0.0%	2.3%	2.3%
Subtotal: Facility/HHA Based Facility Type	728	0.1%	0.0%	2.3%	2.4%
Subtotal: Non-Profit	966	0.0%	-0.1%	2.3%	2.2%
Subtotal: For Profit	3,417	0.0%	0.0%	2.3%	2.3%
Subtotal: Government	130	0.2%	0.2%	2.3%	2.7%
Subtotal: Other	444	-0.3%	0.0%	2.3%	2.0%
Hospice Type and Control: Rural					
Freestanding/Non-Profit	141	-0.2%	0.5%	2.3%	2.6%
Freestanding/For-Profit	348	-0.2%	0.6%	2.3%	2.7%
Freestanding/Government	18	0.2%	0.5%	2.3%	3.0%
Freestanding/Other	48	-0.2%	0.7%	2.3%	2.8%
Facility/HHA Based/Non-Profit	148	-0.3%	0.4%	2.3%	2.4%
Facility/HHA Based/For-Profit	44	0.3%	0.5%	2.3%	3.1%
Facility/HHA Based/Government	68	0.0%	0.5%	2.3%	2.8%
Facility/HHA Based/Other	45	0.2%	0.4%	2.3%	2.9%
Facility Type and Control: Urban					
Freestanding/Non-Profit	459	0.0%	-0.1%	2.3%	2.2%
Freestanding/For-Profit	2,876	0.1%	-0.1%	2.3%	2.3%
Freestanding/Government	22	0.2%	-0.1%	2.3%	2.4%
Freestanding/Other	317	-0.4%	0.0%	2.3%	1.9%
Facility/HHA Based/Non-Profit	218	0.1%	-0.1%	2.3%	2.3%
Facility/HHA Based/For-Profit	149	0.1%	0.2%	2.3%	2.6%
Facility/HHA Based/Government	22	0.4%	0.5%	2.3%	3.2%
Facility/HHA Based/Other	34	0.5%	-0.3%	2.3%	2.5%
Hospice Location: Urban or Rural					

Rural	860	-0.2%	0.5%	2.3%	2.6%
Urban	4,097	0.0%	-0.1%	2.3%	2.2%
Hospice Location: Region of the Country (Census Division)					
New England	156	-0.6%	-0.3%	2.3%	1.4%
Middle Atlantic	277	-0.7%	-0.2%	2.3%	1.4%
South Atlantic	577	0.3%	0.3%	2.3%	2.9%
East North Central	561	-0.2%	0.2%	2.3%	2.3%
East South Central	258	-0.2%	0.7%	2.3%	2.8%
West North Central	408	0.0%	0.3%	2.3%	2.6%
West South Central	967	-0.3%	0.4%	2.3%	2.4%
Mountain	503	0.1%	0.1%	2.3%	2.5%
Pacific	1,201	0.5%	-1.2%	2.3%	1.6%
Outlying	49	-1.3%	3.4%	2.3%	4.4%
Hospice Size					
0 - 3,499 RHC Days (Small)	1,082	0.1%	-0.3%	2.3%	2.1%
3,500-19,999 RHC Days (Medium)	2,227	0.0%	0.0%	2.3%	2.3%
20,000+ RHC Days (Large)	1,648	0.0%	0.0%	2.3%	2.3%

Source: FY 2020 hospice claims data from CCW accessed on January 15, 2021.
Note: The overall total impact reflects the addition of the individual impacts, which includes the overall wage index impact, the labor share impact as well as the 2.3% market basket update.

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

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E. Alternatives Considered

For the FY 2022 Hospice Wage Index and Rate Update proposed rule, we considered alternatives to the calculations of the wage index standardization factor and the labor share standardization factor. Typically, the wage index standardization factor is calculated using the most recent, complete hospice claims data available at the time of rulemaking. However, due to the COVID–19 PHE, we looked at using FY 2019 claims data to determine if there were significant differences between utilizing FY 2019 and FY 2020 claims data for the calculation of the wage index and labor share standardization factors. The wage index standardization factors and labor share standardization factors for each level of care calculated using the FY 2020 claims data that was available at the time of rulemaking did not show significant differences compared to those calculated using FY 2019 claims data. As such, the differences between using FY 2019 and FY 2020 claims data for rate-setting were minimal. Therefore, we will continue our practice of using the most recent, complete hospice claims data to available at the time of rulemaking to set payment rates.

F. Accounting Statement

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), in Table 36, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 36 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this proposed rule. This estimate is based on the data for 4,957 hospices in our impact analysis file, which was constructed using FY 2020 claims available in January 2021. All

expenditures are classified as transfers to hospices.

TABLE 36: Accounting Statement: Classification of Estimated Transfers and Costs, From FY 2021 to FY 2022

Category	Transfers
Annualized Monetized Transfers	$ 530 million*
From Whom to Whom?	Federal Government to Medicare Hospices

*The net increase of $530 million in transfer payments is a result of the 2.3 percent hospice payment update compared to payments in FY 2021.

G. Conclusion

We estimate that aggregate payments to hospices in FY 2022 will increase by $530 million as a result of the market basket update, compared to payments in FY 2021. We estimate that in FY 2022, hospices in urban areas will experience, on average, 2.2 percent increase in estimated payments compared to FY 2021. While hospices in rural areas will experience, on average, 2.6 percent increase in estimated payments compared to FY 2021. Hospices providing services in the Outlying and South Atlantic regions would experience the largest estimated increases in payments of 4.4 percent and 2.9 percent, respectively. Hospices serving patients in areas in the New England and Middle Atlantic regions would experience, on average, the lowest estimated increase of 1.4 percent in FY 2022 payments.

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

List of Subjects in 42 CFR Part 418

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

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

PART 418—HOSPICE CARE

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

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

■ 2. Section 418.3 is amended by adding definitions for ''Pseudo-patient'' and ''Simulation'' in alphabetical order to read as follows:

§ 418.3 Definitions.

* * * * *

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 homecare 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.

* * * * *

■ 3. Section 418.24 is amended by:
■ a. Revising paragraphs (c) introductory text and (c)(9);
■ b. Adding paragraph (c)(10);
■ c. Redesignating paragraphs (d) through (g) as paragraphs (e) through (h); and
■ d. Adding a new paragraph (d).

The revisions and additions read as follows:

§ 418.24 Election of hospice care.

* * * * *

(c) *Content of hospice election statement addendum.* For hospice elections beginning on or after October 1, 2020, in the event that the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the election statement. The election statement addendum must include the following:

* * * * *

(9) Name and signature of the individual (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not the individual's (or representative's) agreement with the hospice's determinations. If a non-hospice provider or Medicare contractor requests the addendum, the non-hospice provider or Medicare contractor are not required to sign the addendum.

(10) Date the hospice furnished the addendum.

(d) *Timeframes for the hospice election statement addendum.* (1) If the addendum is requested within the first 5 days of a hospice election (that is, in the first 5 days of the hospice election date), the hospice must provide this information, in writing, to the individual (or representative), non-hospice provider, or Medicare contractor within 5 days from the date of the request.

(2) If the addendum is requested during the course of hospice care (that is, after the first 5 days of the hospice election date), the hospice must provide this information, in writing, within 3 days of the request to the requesting individual (or representative), non-hospice provider, or Medicare contractor.

(3) If there are any changes to the plan of care during the course of hospice care, the hospice must update the addendum and provide these updates, in writing, to the individual (or representative) in order to communicate these changes to the individual (or representative).

(4) If the individual dies, revokes, or is discharged within the required timeframe for furnishing the addendum (as outlined in paragraphs (d)(1) and (2)

of this section, and before the hospice has furnished the addendum, the addendum would not be required to be furnished to the individual (or representative). The hospice must note the reason the addendum was not furnished to the patient and the addendum would become part of the patient's medical record if the hospice has completed it at the time of discharge, revocation, or death.

(5) If the beneficiary dies, revokes, or is discharged prior to signing the addendum (as outlined in paragraphs (d)(1) and (2) of this section), the addendum would not be required to be furnished to the individual (or representative). The hospice must note the reason the addendum was not signed and the addendum would become part of the patient's medical record.

* * * * *

■ 4. Section 418.76 is amended by revising paragraphs (c)(1) and (h)(1)(iii) to read as follows:

§ 418.76 Condition of participation: Hospice aide and homemaker services.

* * * * *

(c) * * *

(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient or a pseudo-patient during a simulation.

* * * * *

(h) * * *

(1) * * *

(iii) If an area of concern is verified by the hospice during the on-site 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 paragraph (c) of this section.

* * * * *

■ 5. Section 418.309 is amended by revising paragraphs (a)(1) and (2) to read as follows:

§ 418.309 Hospice aggregate cap.

* * * * *

(a) * * *

(1) For accounting years that end on or before September 30, 2016 and end on or after October 1, 2030, the cap amount is adjusted for inflation by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CPI from March 1984 to the fifth month of the cap year.

(2) For accounting years that end after September 30, 2016, and before October 1, 2030, the cap amount is the cap amount for the preceding accounting year updated by the percentage update to payment rates for hospice care for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year as determined pursuant to section 1814(i)(1)(C) of the Act (including the application of any productivity or other adjustments to the hospice percentage update).

* * * * *

■ 6. Section 418.312 is amended by revising paragraph (b) to read as follows:

§ 418.312 Data submission requirements under the hospice quality reporting program.

* * * * *

(b) *Submission of Hospice Quality Reporting Program data.* (1) Standardized set of admission and discharge items Hospices are required to complete and submit an admission Hospice Item Set (HIS) and a discharge HIS for each patient to capture patient-level data, regardless of payer or patient age. The HIS is a standardized set of items intended to capture patient-level data.

(2) Administrative data, such as Medicare claims data, used for hospice quality measures to capture services throughout the hospice stay, are required and automatically meet the HQRP requirements for § 418.306(b)(2).

(3) CMS may remove a quality measure from the Hospice QRP based on one or more of the following factors:

(i) Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better patient outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(v) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(vi) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

* * * * *

Dated: March 29, 2021.

Elizabeth Richter,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 6, 2021.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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