4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS-1810-F]

RIN 0938-AV29

Medicare Program; FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements

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

ACTION: Final rule.

SUMMARY: This final rule updates the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year (FY) 2025. This rule also adopts the most recent Office of Management and Budget statistical area delineations, which will impact the hospice wage index. This rule clarifies current policy related to the "election statement" and the "notice of election", as well as adds clarifying language regarding hospice certification and includes a technical regulation text change to the Conditions of Participation (CoPs). This rule finalizes changes to the Hospice Quality Reporting Program. Finally, this rule summarizes comments received regarding potential implementation of a separate payment mechanism to account for high intensity palliative care services.

DATES: These regulations are effective on October 1, 2024.

FOR FURTHER INFORMATION CONTACT:

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

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

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

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

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose

This final rule updates the hospice wage index, payment rates, and cap amount for Fiscal Year (FY) 2025 as required under section 1814(i) of the Social Security Act (the Act). This rule also finalizes the adoption of the most recent Office of Management and Budget (OMB) statistical area delineations based on data collected during the 2020 Decennial Census, which will result in changes to the hospice wage index. In addition, this rule finalizes the reorganization of the regulations to clarify current policy related to the "election statement" and the "notice of election (NOE)," and adds clarifying language regarding who can certify terminal illness and admit patients to hospice. This rule also summarizes comments solicited regarding a potential policy to account for the increased hospice costs of providing high intensity palliative care services.

Additionally, this rule finalizes the Hospice Quality Reporting Program (HQRP) measures collected through a new collection instrument, the Hospice Outcomes and Patient Evaluation (HOPE); finalizes two HOPE-based measures and lays out the planned trajectory for further development of this instrument; and provides updates on Health Equity, future quality

measures (QMs), and public reporting requirements. We also acknowledge responses on the request for information on potential social determinants of health (SDOH) elements. Finally, this rule also finalizes changes to the Hospice Consumer Assessment of Healthcare Providers and Systems (Hospice CAHPS) Survey.

B. Summary of the Major Provisions

Section III.A.1 of this final rule updates the hospice wage index and makes the application of the updated wage data budget neutral for all four levels of hospice care.

Section III.A.2 of this final rule adopts the new OMB labor market delineations from the July 21, 2023, OMB Bulletin No. 23-01 based on data collected from the 2020 Decennial Census.

Section III.A.3 of this final rule includes the final FY 2025 hospice payment update percentage of 2.9 percent.

Section III.A.4 of this final rule includes updates to hospice payment rates.

Section III.A.5 of this final rule includes an update to the hospice cap amount for FY 2025 by the hospice payment update percentage of 2.9 percent.

In section III.B of this final rule, we make clarifying changes to the hospice Conditions of Participation (CoPs) and adopt clarifying regulations text, with no change to current policy. This includes reorganizing the regulations to clearly identify the distinction between the "election statement" and the "notice of election," as well as including clarifying text changes that align payment regulations and CoPs regarding who may certify terminal illness and determine admission to hospice care. This section also finalizes technical regulations text changes in the Medical Director CoP at § 418.102. In addition, we are making a technical correction in the personnel requirements at § 418.114(b)(9), where we inadvertently used the term "marriage and family counselor" when the correct term is "marriage and family therapist."

In section III.C of this final rule, we include a summary of comments received on a potential policy to account for higher hospice costs involved in the provision of high intensity palliative care treatments.

Finally, in section III.D of this final rule, we finalize HOPE-based process measures; finalize the HOPE instrument; discuss updates to potential future quality measures; and finalize changes to the CAHPS® Hospice Survey.

C. Summary of Impacts

The overall economic impact of this final rule is estimated to be $790 million in increased payments to hospices in FY 2025.

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 the individual's 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. The regulations at § 418.22(b)(3) require that the certification and recertification forms, or an addendum to the certification and recertification forms, include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

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

If, in the judgment of the hospice interdisciplinary group (as specified at § 418.56(a)(1)), 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 home for hospice care (routine home care) (RHC). Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an

individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. CHC may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with the regulations at § 418.204. A minimum of 8 hours of nursing care or nursing and aide care must be furnished on a particular day to qualify for the CHC rate (§ 418.302(e)(4)).

Hospices covered by this rule must comply with applicable civil rights laws, including, section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, which require covered programs to take appropriate steps to ensure effective communication with individuals with disabilities and companions with disabilities, including the provisions of auxiliary aids and services when necessary to afford qualified individuals with disabilities, including applicants, participants, beneficiaries, companions and members of the public, an equal opportunity to participate in, and enjoy the benefits of, a service, program or activity of a recipient or public entity.[1] Further information may be found at:https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin in federally assisted programs or activities. The Office for Civil Rights (OCR) interprets this to require that recipients of Federal financial assistance take reasonable steps to provide meaningful access to their programs or activities to individuals with limited English proficiency (LEP).[2] Similarly, section 1557's of the Affordable Care Act implementing regulation requires covered entities to take reasonable steps to provide meaningful access to LEP individuals in federally funded health programs and activities (45 CFR 92.201(a)). Meaningful

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

[2] HHS OCR, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* 68 Fed. Reg 47311 (Aug. 8, 2003), https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html.

access may require the provision of interpreter services and translated materials (45 CFR 92.201(c)).[3]

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 biological products); 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 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).

[3] The Section 1557 final rule has been challenged in several courts and is not currently in effect in Texas and Montana. Additional information about the rule is available here: Section 1557 of the Patient Protection and Affordable Care Act | HHS.gov.

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

C. Medicare Payment for Hospice Care

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

While payment made to hospices is to cover all items, services, and drugs for the palliation and management of the terminal illness and related conditions, federal funds cannot be used for prohibited activities, even in the context of a per diem payment. For example, hospices are prohibited from playing a role in medical aid in dying (MAID) where such practices have been legalized in certain States. The Assisted Suicide Funding Restriction Act of 1997 (Pub. L. 105-12, April 30, 1997) prohibits the use of federal funds to provide or pay for any health care item or service or health benefit coverage for the purpose of causing, or assisting to

cause, the death of any individual including "mercy killing, euthanasia, or assisted suicide." However, the prohibition does not pertain to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing or accelerating death.

The Medicare hospice benefit has been revised and refined since its implementation after various Acts of Congress and Medicare rules. For a historical list of changes and regulatory actions, we refer readers to the background section of previous Hospice Wage Index and Payment Rate Update rules.[4]

III. Provisions of the Final Rule

A. Final FY 2025 Hospice Wage Index and Rate Update

1. Final FY 2025 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. 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 Metropolitan Statistical Area (MSA) 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 September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018, OMB Bulletin No. 18–03. OMB Bulletin No. 18-04 made revisions to the delineations of MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas (CSA), and guidance on uses of the delineations in these areas. This bulletin provided the delineations of all MSAs, Metropolitan Divisions, Micropolitan Statistical Areas, CSAs, and New England City and Town Areas in the

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

United States and Puerto Rico based on the standards published on June 28, 2010, in the Federal Register (75 FR 37246 through 37252), and Census Bureau data. A copy of the September 14, 2018, bulletin is available online at: https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf. In the FY 2021 Hospice Wage Index final rule (85 FR 47080), we finalized our proposal to adopt the revised OMB delineations from the September 14, 2018, OMB Bulletin 18–04 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). 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 CSA, and changes to New England City and Town Area (NECTA) delineations. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we stated that if appropriate, we would propose any updates from OMB Bulletin No. 20-01 in future rulemaking. After reviewing OMB Bulletin No. 20-01, we determined that the changes in Bulletin 20-01 encompassed delineation changes that would not affect the Medicare wage index for FY 2022. Specifically, the updates consisted of changes to NECTA delineations and the redesignation of a single rural county into a newly created Micropolitan Statistical Area. The Medicare wage index does not utilize NECTA definitions, and, as most recently discussed in the FY 2021 Hospice Wage Index final rule (85 FR 47070), we include hospitals located in Micropolitan Statistical Areas in each State's rural wage index.

As described in the August 8, 1997, Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. As previously discussed, the pre-floor, pre-reclassified hospital wage index values below 0.8000 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8000. 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 0.8000, 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 0.8000, County B's hospice wage index would be 0.8000.

In the FY 2023 Hospice Wage Index final rule (87 FR 45673), we finalized for FY 2023 and subsequent years, the application of a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline, so that a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. When calculating the 5-percent cap on wage index decreases we start with the current fiscal year's pre-floor, pre-reclassification hospital wage index value for a core-based statistical area (CBSA) or statewide rural area and if that wage index value is below 0.8000, we apply the hospice floor as discussed here. Next, we compare the current fiscal year's wage index value after the application of the hospice floor to the final wage index value from the previous fiscal year. If the current fiscal year's wage index value is less than 95 percent of the previous year's wage index value, the 5-percent cap on wage index decreases would be applied and the final wage index value would be set equal to 95 percent of the previous fiscal year's wage index value. If the 5-percent cap is applied in one fiscal year, then in the subsequent fiscal year, that year's pre-floor, pre-reclassification hospital

wage index would be used as the starting wage index value and adjusted by the hospice floor. The hospice floor adjusted wage index value would be compared to the previous fiscal year's wage index which had the 5-percent cap applied. If the hospice floor adjusted wage index value for that fiscal year is less than 95 percent of the capped wage index from the previous year, then the 5-percent cap would be applied again, and the final wage index value would be 95 percent of the capped wage index from the previous fiscal year. Using the example previously stated, 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. If County A had a wage index value of 0.6200 in the previous fiscal year, then we would compare 0.4593 to the previous fiscal year's wage index value. Since 0.4593 is less than 95 percent of 0.6200, then County A's hospice wage index would be 0.5890, which is equal to 95-percent of the previous fiscal year's wage index value of 0.6200. In the next fiscal year, the updated wage index value would be compared to the wage index value of 0.5890.

Previously, this methodology was applied to all the counties that make up the CBSA or rural area. However, as discussed in section III.A.2.f of this final rule, because we are adopting the revised OMB delineations this methodology will also be applied to individual counties.

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. For FY 2025, we proposed that the hospice wage index would be based on the FY 2025 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021 (FY 2021 cost report data). We also stated that the proposed FY 2025 hospice wage index would not consider any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The regulations that govern hospice payment do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor provisions that exist for Inpatient Prospective Payment System (IPPS) hospitals. The reclassification provision found in section

1886(d)(10) of the Act is specific to hospitals. Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33) provides that the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. This rural floor provision is also specific to hospitals. Because the reclassification and the hospital rural floor policies apply to hospitals only, and not to hospices, we continue to believe the use of the pre-floor and pre-reclassified hospital wage index results is the most appropriate adjustment to the labor portion of the hospice payment rates. This position is longstanding and consistent with other Medicare payment systems, for example, the skilled nursing facility prospective payment system (SNF PPS), the inpatient rehabilitation facility prospective payment system (IRF PPS), and the home health prospective payment system (HH PPS). However, the hospice wage index does include the hospice floor, which is applicable to all CBSAs, both rural and urban. The hospice floor adjusts pre-floor, pre-reclassified hospital wage index values below 0.8000 by a 15 percent increase subject to a maximum wage index value of 0.8000. We proposed that the FY 2025 hospice wage index would also include the 5-percent cap on wage index decreases. The appropriate wage index value would be applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

We received 28 comments on the proposed FY 2025 hospice wage index from various stakeholders including hospices, national industry associations, and the Medicare Payment Advisory Commission (MedPAC). A summary of these comments and our responses appear below:

Comment: One commenter expressed concern with the wage index assigned to Montgomery County, Maryland (MD). This commenter stated that Montgomery County, MD has a similar cost of living compared to Washington, D.C. and shares the same labor market

when competing for labor; therefore, hospices in Montgomery County should be reimbursed at the same level as hospices in Washington, D.C. This commenter stated that hospices in Montgomery County are at a long-term competitive disadvantage due to a Medicare hospice federal payment inequity involving CBSAs and recommended that CMS assign the hospice wage index valuation for the Washington, D.C. CBSA to the Montgomery/Frederick County CBSA for a time-limited period, such as 5 years, in order to evaluate the impact on Montgomery County hospices.

Response: We thank the commenter for the recommendation. However, we continue to believe that the OMB's geographic area delineations represent a useful proxy for differentiating between labor markets and that the geographic area delineations are appropriate for use in determining Medicare hospice payments. The general concept of the CBSAs is that of an area containing a recognized population nucleus and adjacent communities that have a high degree of integration with that nucleus. The purpose of the 2020 standards for delineating Core Based Statistical Areas is to provide nationally consistent definitions for collecting, tabulating, and publishing federal statistics for a set of geographic areas. CBSAs include adjacent counties that have a minimum of 25 percent commuting to the central counties of the area. Based on the OMB's current delineations, Montgomery County belongs in a separate CBSA from the areas defined in the Washington, D.C. CBSA (CBSA 47764). Unlike IPPS hospitals, IRFs, and SNFs, where each provider uses a single wage index value, hospice agencies may serve multiple CBSAs and be reimbursed based on more than one wage index value. Payments are based upon the location of the beneficiary for routine and continuous home care or the location of the facility for respite and general inpatient care. Hospices in Montgomery County, Maryland may provide RHC and CHC to patients in the Washington, D.C. CBSA, as well as to patients in other surrounding CBSAs. We have used CBSAs for determining hospice payments since FY 2006 and continue to believe that using the most current OMB delineations provides an accurate representation of geographic variation in wage levels and do not believe it would be appropriate

to allow hospices to opt for, or be assigned, a CBSA designation with a higher wage index value. However, if a future OMB Bulletin updates the designation for Montgomery County, Maryland, we would propose this change through our normal rulemaking process.

Comment: A few commenters opposed the use of the IPPS wage index as the basis for the hospice wage index. In general, these commenters stated that the use of hospital wage data is inappropriate and recommended that CMS utilize more appropriate wage information for the hospice wage index. These commenters expressed concern that the hospital wage index is derived from cost report wage data submitted by hospitals which explicitly excludes hospice wage costs. Commenters suggested that the exclusion of hospice costs undermines the accuracy of wage adjustments for hospice providers and has the potential to lead to inadequate services for terminally ill beneficiaries. Additionally, two commenters also expressed concern with the lag in the hospital cost report data used as the basis for the hospice wage index. One commenter stated that the lag in the wage index data used in the proposed rule likely means that any increase in reimbursement rates will be quickly, and possibly completely, subsumed by recent and anticipated inflation rates.

Response: We appreciate the commenters concerns; however, these comments are outside the scope of the proposed rule, as we did not propose changes to our hospice wage index methodology. Changes to the hospice wage index methodology, including changes to the underlying data used to create the hospice wage index, would have to go through notice and comment rulemaking. Furthermore, we continue to believe the use of the pre-floor and pre-reclassified hospital wage index results is the most appropriate adjustment to the labor portion of the hospice payment rates. This position is longstanding and consistent with other Medicare payment systems; however, we will consider these comments in the future if CMS does consider changes to this methodology.

Comment: A few commenters recommended more far-reaching revisions to the hospice wage index methodology. Some commenters, including MedPAC, recommended an overhaul of

the entire hospice wage index methodology. One commenter stated that the time is long overdue for CMS to develop and implement a wage index model that is consistent across all provider types so that all providers have a level playing field from which to compete for personnel. MedPAC recommended that existing Medicare wage index policies be repealed, including current exceptions, and to phase in a new Medicare wage index system for hospitals and other types of providers that uses all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type; reflects local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and smooths wage index differences across adjacent local areas. In addition, many commenters recommended allowing hospices to take advantage of wage index protections afforded to hospitals such as geographic redesignation and the rural floor. One commenter suggested that CMS investigate how MedPAC's wage index proposal would impact hospices and work with stakeholders, including Congress, to determine how to implement a fairer system that also takes into account increased labor costs.

Response: We appreciate the commenters' recommendations; however, these comments are outside the scope of the proposed rule, as we did not propose changes to our hospice wage index methodology. Any changes regarding the adjustment of the hospice payments to account for geographic wage differences, beyond the wage index proposals discussed in the FY 2025 Hospice Wage Index and Rate Update proposed rule, would require notice and comment rulemaking.

Comment: Several commenters also expressed concern that hospices are not given the opportunity for geographic reclassification like hospitals. These commenters recommended that hospices be allowed to reclassify to a different CBSA to receive a higher wage index in order to compete with hospitals and other health systems for the same labor pool. One commenter stated that the inability to reclassify a hospice's wage index means the hospice wage index often fails to reflect true labor costs accurately, placing the hospice at a competitive and financial

disadvantage. Another commenter recommended that reclassification be allowed for provider-based home health and hospice providers who are a part of a hospital and/or health system. Many commenters also recommended that CMS reinstitute the rural floor policy so that no hospice serving patients in urban areas is paid below the rural wage index value of the State. These commenters stated that hospices are at a competitive disadvantage because they are unable to take advantage of geographic reclassification and the rural floor provisions that are allowed for hospitals.

Response: We remind stakeholders that the statutory provisions that govern hospice payment do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor provisions that exist for IPPS hospitals. The reclassification provision found in section 1886(d)(10) of the Act is specific to hospitals. Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33) provides that the area wage index applicable to any hospital that is in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. This rural floor provision is also specific to hospitals. Because the reclassification provision and the hospital rural floor apply only to hospitals, and not to hospices (even those hospices that are affiliated with a hospital or other health care system), we continue to believe the use of the pre-floor and pre-reclassified hospital wage index results is the most appropriate adjustment to the labor portion of the hospice payment rates. However, we note that hospices do receive the hospice floor which adjusts the pre-floor, pre-reclassified hospital wage index values below 0.8000 by a 15 percent increase subject to a maximum wage index value of 0.8000 and the 5-percent cap on wage index decreases.

Comment: Two commenters encouraged CMS to add details and transparency to the wage index section of the rule. These commenters requested that CMS describe in detail how the wage index is calculated, the basis in the hospital cost report, and the role of the wage index standardization factor. Commenters requested this information so that hospices receive more information on how and why year to year wage index variation occurs.

Response: We thank the commenters for their recommendations. In reference to the commenters' recommendation for more details describing how the pre-floor pre-reclassified wage index is calculated, we refer readers to the FY 2025 IPPS proposed rule (89 FR 36139 through 36159) for additional information on the cost report worksheets used to calculate the wage index, information on how those worksheets are validated, the process for hospitals to request corrections, and the method for calculating the proposed unadjusted wage index. Once we receive the pre-floor, pre-reclassified wage index values as discussed, those values are then adjusted by the hospice floor so that all wage index values lower than 0.8000 are increased by 15 percent up to 0.8000. The hospice floor adjusted wage index values are subsequently updated by the permanent 5-percent cap on wage index decreases so that the wage index for the current fiscal year is not less than 95 percent of the wage index value the previous fiscal year. Regarding the wage index standardization factors, we finalized in the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), a policy of applying wage index standardization factors for each level of care to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. In order to calculate the wage index standardization factor, we simulate total payments using FY 2023 hospice utilization claims data with the FY 2024 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, old OMB delineations, and the 5-percent cap on wage index decreases) and FY 2024 payment rates and compare that total to our simulation of total payments using FY 2023 utilization claims data, the final FY 2025 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the revised OMB delineations, with the 5-percent cap on wage index decreases) and FY 2024 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2024 wage index and FY 2024 payment rates for each level of care by the FY 2025 wage index and FY 2024 payment rates, we obtain a wage index standardization factor for each level of care. The wage index

standardization factors for each level of care are then applied to the national payment amounts for that level of care to calculate the final FY 2025 payment amounts.

Final Decision: We are finalizing our proposal to use the FY 2025 pre-floor, pre-reclassified hospital wage index data as the basis for the FY 2025 hospice wage index. The wage index applicable for FY 2025 is available on our website at: https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/ Hospice/Hospice-Wage-Index. The hospice wage index for FY 2025 is effective October 1, 2024, through September 30, 2025.

There exist some geographic areas where there are no hospitals, and thus, no hospital wage data on which to base the calculation of the hospice wage index. In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all the 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 2025, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia. The FY 2025 final wage index value for Hinesville-Fort Stewart, Georgia is 0.8872.

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). For FY 2025, as part of our proposal to adopt the revised OMB delineations discussed further in section III.A.2 of this final rule, we proposed that rural North Dakota would now become a rural area without a hospital from which hospital wage data can be derived. Therefore, to calculate the wage index for rural area 99935, North Dakota, we proposed to use as a proxy, the average pre-floor, pre-reclassified hospital wage data (updated by the hospice floor)

from the contiguous CBSAs: CBSA 13900-Bismark, ND, CBSA 22020-Fargo, ND-MN, CBSA 24220-Grand Forks, ND-MN and CBSA 33500, Minot, ND, which resulted in a proposed FY 2025 hospice wage index of 0.8446 for rural North Dakota.

While no commenters expressly opposed or supported this proposal, we did receive one comment acknowledging the proposal to shift rural North Dakota to a rural area without a hospital from which hospital data can be formulated. We are finalizing our proposal to use as a proxy the average pre-floor, pre-reclassified hospital wage data (updated by the hospice floor) from the contiguous CBSAs: CBSA 13900-Bismark, ND, CBSA 22020-Fargo, ND-MN, CBSA 24220-Grand Forks, ND-MN and CBSA 33500, Minot, ND. For this final rule, using updated data, the final FY 2025 hospice wage index for rural North Dakota is 0.8545.

TABLE 1: Wage Index For Rural North Dakota.

CBSA Code	CBSA Name	Hospice Wage Index
13900	Bismarck, ND	0.8982
22020	Fargo, ND-MN	0.8726
24220	Grand Forks, ND-MN	0.8000
33500	Minot, ND	0.8470
	Final FY 2025 Hospice Wage Index	**0.8545**

Note: CBSA 24220 Grand Forks, ND-MN is adjusted by the hospice floor and CBSA 33500 Minot, ND is adjusted by the 5-percent cap.

Previously, the only rural area without a hospital from which hospital wage data could be derived was in Puerto Rico. However, for rural Puerto Rico, we did not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity of almost all of Puerto Rico's various urban areas to non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we used the most recent wage index previously available for that area which was 0.4047, subsequently adjusted by the hospice floor for an adjusted wage index value of 0.4654. For FY 2025, we noted that as part of our proposal to adopt the revised OMB delineations discussed further in section III.A.2.c of this final rule, there would now be a hospital in rural Puerto Rico from which hospital wage data can be derived. Therefore, we proposed that

the wage index for rural Puerto Rico would now be based on the hospital wage data for the area instead of the previously available pre-hospice floor wage index of 0.4047, which equaled an adjusted wage index value of 0.4654. The FY 2025 proposed pre-hospice floor unadjusted wage index for rural Puerto Rico would be 0.2520, and is subsequently adjusted by the hospice floor to equal 0.2898. Because 0.2898 is more than a 5-percent decline in the FY 2024 wage index, the adjusted FY 2025 wage index with the 5-percent cap applied would equal 0.95 multiplied by 0.4654 (that is, the FY 2024 wage index with floor), which resulted in a proposed wage index of 0.4421.

We did not receive any comments on our proposal to use hospital wage data to calculate the wage index of rural Puerto Rico instead of the previously available hospice floor adjusted wage index of 0.4654. We are finalizing this policy as proposed. For FY 2025 the final hospice wage index for rural Puerto Rico is 0.2510, subsequently adjusted by the hospice floor which equals 0.2887. Because 0.2887 is more than a 5-percent decline in the FY 2024 wage index, the adjusted FY 2025 wage index with the 5-percent cap applied will equal 0.95 multiplied by 0.4654 (that is, the FY 2024 wage index with floor), which results in a final wage index of 0.4421.

Finally, due to the proposed adoption of the revised OMB delineations discussed in section III.A.2.c of this final rule, we noted that Delaware, which was previously an all-urban State, would now have one rural area with a hospital from which hospital wage data can be derived. As such, the proposed FY 2025 wage index for rural area 99908 Delaware was 1.0429. We did not receive any comments on our proposal to use hospital wage data to calculate the wage index of rural Delaware. We are finalizing our proposal and the FY 2025 final hospice wage index for rural Delaware is 1.0385.

2. Implementation of New Labor Market Delineations

As discussed, on July 21, 2023, OMB issued Bulletin No. 23-01, which updates and supersedes OMB Bulletin No. 20-01, issued on March 6, 2020. OMB Bulletin No. 23-01

establishes revised delineations for the MSAs, Micropolitan Statistical Areas, CSAs, and Metropolitan Divisions, collectively referred to as Core Based Statistical Areas (CBSAs). According to OMB, the delineations reflect the 2020 Standards for Delineating Core Based Statistical Areas (the "2020 Standards"), which appeared in the Federal Register (86 FR 37770 through 37778) on July 16, 2021, and application of those standards to Census Bureau population and journey-to-work data (for example, 2020 Decennial Census, American Community Survey, and Census Population Estimates Program data). A copy of OMB Bulletin No. 23-01 is available online at: https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf.

The July 21, 2023, OMB Bulletin No. 23-01 contains a number of significant changes. For example, there are new CBSAs, urban counties that have become rural, rural counties that have become urban, and existing CBSAs that have been split apart. We believe it is important for the hospice wage index to use the latest OMB delineations available in order to maintain the most accurate and up-to-date payment system, reflecting the reality of population shifts and labor market conditions. We further believe that using the most current OMB delineations would increase the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels. We proposed to implement the new OMB delineations as described in the July 21, 2023, OMB Bulletin No. 23–01 for the hospice wage index effective beginning in FY 2025. A summary of comments and our responses on this overall proposal, and on the more specific changes discussed in sections III.A.2.c through III.A.2.f of this final rule that occur as a result of this final policy, are discussed further in this document.

a. Micropolitan Statistical Areas

As discussed in the FY 2006 Hospice Wage Index and Payment Rate Update proposed rule (70 FR 22397) and final rule (70 FR 45132), we considered how to use the Micropolitan Statistical Area definitions in the calculation of the wage index. Previously, OMB defined a "Micropolitan Statistical Area" as a "CBSA" "associated with at least one urban cluster that has

a population of at least 10,000, but less than 50,000" (75 FR 37252). We refer to these as Micropolitan Areas. After extensive impact analysis, consistent with the treatment of these areas under the IPPS as discussed in the FY 2005 IPPS final rule (69 FR 49029), we determined the best course of action would be to treat Micropolitan Areas as "rural" and include them in the calculation of each State's Hospice rural wage index (70 FR 22397 and 70 FR 45132). Thus, the hospice statewide rural wage index has been determined using IPPS hospital data from hospitals located in non-MSAs. In the FY 2021 Hospice final rule (85 FR 47074, 47080), we finalized a policy to continue to treat Micropolitan Areas as "rural" and to include Micropolitan Areas in the calculation of each State's rural wage index.

The OMB "2020 Standards" continues to define a "Micropolitan Statistical Area" as a CBSA with at least one Urban Area that has a population of at least 10,000, but less than 50,000. The Micropolitan Statistical Area comprises the central county or counties containing the core, plus adjacent outlying counties having a high degree of social and economic integration with the central county, or counties as measured through commuting. (86 FR 37778). Overall, there are the same number of Micropolitan Areas (542) under the new OMB delineations based on the 2020 Census as there were using the 2010 Census. We note, however, that a number of urban counties have switched status and have joined or become Micropolitan Areas, and some counties that once were part of a Micropolitan Area, and thus were treated as rural, have become urban based on the 2020 Decennial Census data. We believe that the best course of action would be to continue our established policy and include Micropolitan Areas in each State's rural wage index as these areas continue to be defined as having relatively small urban cores (populations of 10,000 to 49,999). Therefore, in conjunction with our proposal to implement the new OMB labor market delineations beginning in FY 2025, and consistent with the treatment of Micropolitan Areas under the IPPS, we also proposed to continue to treat Micropolitan Areas as ''rural'' and to include Micropolitan Areas in the calculation of each State's rural wage index.

Final Decision: We did not receive any comments on our proposal to continue to treat Micropolitan Areas as rural and to include those areas in the calculation of each State's rural wage index. We are finalizing this policy as proposed.

b. Change to County-Equivalents in the State of Connecticut

In a June 6, 2022, Notice (87 FR 34235 - 34240), the Census Bureau announced that it was implementing the State of Connecticut's request to replace the eight counties in the State with nine new "Planning Regions". Planning regions are included in OMB Bulletin No. 23-01 and now serve as county-equivalents within the CBSA system. We evaluated the change and proposed to adopt the planning regions as county equivalents for wage index purposes. We believe it is necessary to adopt this migration from counties to planning region county-equivalents in order to maintain consistency with our established policy of adopting the most recent OMB updates.

Final Decision: We did not receive any comments on our proposal to adopt the Connecticut planning regions as county equivalents for wage index purposes. We are finalizing this policy as proposed. We are providing the following crosswalk in Table 2 for counties located in Connecticut with the current and final FIPS county and county-equivalent codes and CBSA assignments.

TABLE 2: **Crosswalk of Connecticut County Equivalents**

FIPS County Code	**County**	**Old CBSA or non-urban area**	**New FIPS County Code**	**FY 2025 Planning Region**	**New CBSA or non-urban area**
09001	FAIRFIELD	14860	09190	WESTERN CONNECTICUT	14860
09001	FAIRFIELD	14860	09120	GREATER BRIDGEPORT	14860
09003	HARTFORD	25540	09110	CAPITOL	25540
09005	LITCHFIELD	99907	09160	NORTHWEST HILLS	99907
09007	MIDDLESEX	25540	09130	LOWER CONNECTICUT RIVER VALLEY	25540
09009	NEW HAVEN	35300	09140	NAUGATUCK VALLEY	47930
09009	NEW HAVEN	35300	09170	SOUTH CENTRAL CONNECTICUT	35300

09011	NEW LONDON	35980	09180	SOUTHEASTERN CONNECTICUT	35980
09013	TOLLAND	25540	09110	CAPITOL	25540
09015	WINDHAM	49340	09150	NORTHEASTERN CONNECTICUT	99907

c. Urban Counties That Would Become Rural

Under the revised OMB statistical area delineations (based upon OMB Bulletin No. 23-01), a total of 53 counties (and county equivalents) that are currently considered urban would be considered rural beginning in FY 2025. Table 3 lists the 53 counties that will become rural when we implement the revised OMB delineations.

TABLE 3: Urban Counties That Would Change to Rural Status

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name
01129	WASHINGTON	AL	33660	Mobile, AL
05025	CLEVELAND	AR	38220	Pine Bluff, AR
05047	FRANKLIN	AR	22900	Fort Smith, AR-OK
05069	JEFFERSON	AR	38220	Pine Bluff, AR
05079	LINCOLN	AR	38220	Pine Bluff, AR
10005	SUSSEX	DE	41540	Salisbury, MD-DE
13171	LAMAR	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA
16077	POWER	ID	38540	Pocatello, ID
17057	FULTON	IL	37900	Peoria, IL
17077	JACKSON	IL	16060	Carbondale-Marion, IL
17087	JOHNSON	IL	16060	Carbondale-Marion, IL
17183	VERMILION	IL	19180	Danville, IL
17199	WILLIAMSON	IL	16060	Carbondale-Marion, IL
18121	PARKE	IN	45460	Terre Haute, IN
18133	PUTNAM	IN	26900	Indianapolis-Carmel-Anderson, IN
18161	UNION	IN	17140	Cincinnati, OH-KY-IN
21091	HANCOCK	KY	36980	Owensboro, KY
21101	HENDERSON	KY	21780	Evansville, IN-KY
22045	IBERIA	LA	29180	Lafayette, LA
24001	ALLEGANY	MD	19060	Cumberland, MD-WV
24047	WORCESTER	MD	41540	Salisbury, MD-DE
25011	FRANKLIN	MA	44140	Springfield, MA
26155	SHIAWASSEE	MI	29620	Lansing-East Lansing, MI
27075	LAKE	MN	20260	Duluth, MN-WI
28031	COVINGTON	MS	25620	Hattiesburg, MS
31051	DIXON	NE	43580	Sioux City, IA-NE-SD
36123	YATES	NY	40380	Rochester, NY
37049	CRAVEN	NC	35100	New Bern, NC
37077	GRANVILLE	NC	20500	Durham-Chapel Hill, NC

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name
37085	HARNETT	NC	22180	Fayetteville, NC
37087	HAYWOOD	NC	11700	Asheville, NC
37103	JONES	NC	35100	New Bern, NC
37137	PAMLICO	NC	35100	New Bern, NC
42037	COLUMBIA	PA	14100	Bloomsburg-Berwick, PA
42085	MERCER	PA	49660	Youngstown-Warren-Boardman, OH-PA
42089	MONROE	PA	20700	East Stroudsburg, PA
42093	MONTOUR	PA	14100	Bloomsburg-Berwick, PA
42103	PIKE	PA	35084	Newark, NJ-PA
45027	CLARENDON	SC	44940	Sumter, SC
48431	STERLING	TX	41660	San Angelo, TX
49003	BOX ELDER	UT	36260	Ogden-Clearfield, UT
51113	MADISON	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV
51175	SOUTHAMPTON	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
51620	FRANKLIN CITY	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
54035	JACKSON	WV	16620	Charleston, WV
54043	LINCOLN	WV	16620	Charleston, WV
54057	MINERAL	WV	19060	Cumberland, MD-WV
55069	LINCOLN	WI	48140	Wausau-Weston, WI
72001	ADJUNTAS	PR	38660	Ponce, PR
72055	GUANICA	PR	49500	Yauco, PR
72081	LARES	PR	10380	Aguadilla-Isabela, PR
72083	LAS MARIAS	PR	32420	Mayagüez, PR
72141	UTUADO	PR	10380	Aguadilla-Isabela, PR

d. Rural Counties That Would Become Urban

Under the revised OMB statistical area delineations (based upon OMB Bulletin No. 23-01), a total of 54 counties (and county equivalents) that are currently located in rural areas will be considered located in urban areas under the revised OMB delineations beginning in FY 2025. Table 4 lists the 54 counties that will be urban if we implement the revised OMB delineations beginning in FY 2025.

TABLE 4: Rural Counties That Would Change to Urban Status

FIPS County Code	County Name	State	Final FY 2025 CBSA	Final FY 2025 CBSA Name
01087	MACON	AL	12220	Auburn-Opelika, AL
01127	WALKER	AL	13820	Birmingham, AL
12133	WASHINGTON	FL	37460	Panama City-Panama City Beach, FL
13187	LUMPKIN	GA	12054	Atlanta-Sandy Springs-Roswell, GA
15005	KALAWAO	HI	27980	Kahului-Wailuku, HI
17053	FORD	IL	16580	Champaign-Urbana, IL
17127	MASSAC	IL	37140	Paducah, KY-IL
18159	TIPTON	IN	26900	Indianapolis-Carmel-Greenwood, IN
18179	WELLS	IN	23060	Fort Wayne, IN
20021	CHEROKEE	KS	27900	Joplin, MO-KS
21007	BALLARD	KY	37140	Paducah, KY-IL
21039	CARLISLE	KY	37140	Paducah, KY-IL
21127	LAWRENCE	KY	26580	Huntington-Ashland, WV-KY-OH
21139	LIVINGSTON	KY	37140	Paducah, KY-IL
21145	MC CRACKEN	KY	37140	Paducah, KY-IL
21179	NELSON	KY	31140	Louisville/Jefferson County, KY-IN
22053	JEFFRSON DAVIS	LA	29340	Lake Charles, LA
22083	RICHLAND	LA	33740	Monroe, LA
26015	BARRY	MI	24340	Grand Rapids-Wyoming-Kentwood, MI
26019	BENZIE	MI	45900	Traverse City, MI
26055	GRAND TRAVERSE	MI	45900	Traverse City, MI
26079	KALKASKA	MI	45900	Traverse City, MI
26089	LEELANAU	MI	45900	Traverse City, MI
27133	ROCK	MN	43620	Sioux Falls, SD-MN
28009	BENTON	MS	32820	Memphis, TN-MS-AR
28123	SCOTT	MS	27140	Jackson, MS
30007	BROADWATER	MT	25740	Helena, MT
30031	GALLATIN	MT	14580	Bozeman, MT
30043	JEFFERSON	MT	25740	Helena, MT
30049	LEWIS AND CLARK	MT	25740	Helena, MT
30061	MINERAL	MT	33540	Missoula, MT
32019	LYON	NV	39900	Reno, NV
37125	MOORE	NC	38240	Pinehurst-Southern Pines, NC
38049	MCHENRY	ND	33500	Minot, ND
38075	RENVILLE	ND	33500	Minot, ND
38101	WARD	ND	33500	Minot, ND
39007	ASHTABULA	OH	17410	Cleveland, OH
39043	ERIE	OH	41780	Sandusky, OH
41013	CROOK	OR	13460	Bend, OR
41031	JEFFERSON	OR	13460	Bend, OR
42073	LAWRENCE	PA	38300	Pittsburgh, PA
45087	UNION	SC	43900	Spartanburg, SC
46033	CUSTER	SD	39660	Rapid City, SD

FIPS County Code	County Name	State	Final FY 2025 CBSA	Final FY 2025 CBSA Name
47081	HICKMAN	TN	34980	Nashville-Davidson--Murfreesboro--Franklin, TN
48007	ARANSAS	TX	18580	Corpus Christi, TX
48035	BOSQUE	TX	47380	Waco, TX
48079	COCHRAN	TX	31180	Lubbock, TX
48169	GARZA	TX	31180	Lubbock, TX
48219	HOCKLEY	TX	31180	Lubbock, TX
48323	MAVERICK	TX	20580	Eagle Pass, TX
48407	SAN JACINTO	TX	26420	Houston-Pasadena-The Woodlands, TX
51063	FLOYD	VA	13980	Blacksburg-Christiansburg-Radford, VA
51181	SURRY	VA	47260	Virginia Beach-Chesapeake-Norfolk, VA-NC
55123	VERNON	WI	29100	La Crosse-Onalaska, WI-MN

e. Urban Counties That Would Move to a Different Urban CBSA Under the Revised OMB Delineations

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to a new or existing urban CBSA under our proposal to adopt the revised OMB delineations. In other cases, applying the new OMB delineations would involve a change only in CBSA name or number, while the CBSA would continue to encompass the same constituent counties. For example, CBSA 35154 (New Brunswick-Lakewood, NJ) would experience both a change to its number and its name, and become CBSA 29484 (Lakewood-New Brunswick, NJ), while all three of its constituent counties would remain the same. In other cases, only the name of the CBSA would be modified. Table 5 lists CBSAs that would change in name and/or CBSA number only, but the constituent counties would not change (except in instances where an urban county became rural, or a rural county became urban, as discussed in the previous sections).

TABLE 5: Urban Areas With CBSA Name And/or Number Change

Current CBSA Code	Current CBSA Name	Final FY 2025 CBSA Code	Final FY 2025 CBSA Name
10380	Aguadilla-Isabela, PR	10380	Aguadilla, PR
10540	Albany-Lebanon, OR	10540	Albany, OR
12420	Austin-Round Rock-Georgetown, TX	12420	Austin-Round Rock-San Marcos, TX
12540	Bakersfield, CA	12540	Bakersfield-Delano, CA
13820	Birmingham-Hoover, AL	13820	Birmingham, AL
13980	Blacksburg-Christiansburg, VA	13980	Blacksburg-Christiansburg-Radford, VA
15260	Brunswick, GA	15260	Brunswick-St. Simons, GA
15680	California-Lexington Park, MD	30500	Lexington Park, MD
16540	Chambersburg-Waynesboro, PA	16540	Chambersburg, PA
16984	Chicago-Naperville-Evanston, IL	16984	Chicago-Naperville-Schaumburg, IL
17460	Cleveland-Elyria, OH	17410	Cleveland, OH
19430	Dayton-Kettering, OH	19430	Dayton-Kettering-Beavercreek, OH
19740	Denver-Aurora-Lakewood, CO	19740	Denver-Aurora-Centennial, CO
21060	Elizabethtown-Fort Knox, KY	21060	Elizabethtown, KY
21780	Evansville, IN-KY	21780	Evansville, IN
21820	Fairbanks, AK	21820	Fairbanks-College, AK
22660	Fort Collins, CO	22660	Fort Collins-Loveland, CO
23224	Frederick-Gaithersburg-Rockville, MD	23224	Frederick-Gaithersburg-Bethesda, MD
23844	Gary, IN	29414	Lake County-Porter County-Jasper County, IN
24340	Grand Rapids-Kentwood, MI	24340	Grand Rapids-Wyoming-Kentwood, MI
24860	Greenville-Anderson, SC	24860	Greenville-Anderson-Greer, SC
25940	Hilton Head Island-Bluffton, SC	25940	Hilton Head Island-Bluffton-Port Royal, SC
26380	Houma-Thibodaux, LA	26380	Houma-Bayou Cane-Thibodaux, LA
26420	Houston-The Woodlands-Sugar Land, TX	26420	Houston-Pasadena-The Woodlands, TX
26900	Indianapolis-Carmel-Anderson, IN	26900	Indianapolis-Carmel-Greenwood, IN
27900	Joplin, MO	27900	Joplin, MO-KS
27980	Kahului-Wailuku-Lahaina, HI	27980	Kahului-Wailuku, HI
29404	Lake County-Kenosha County, IL-WI	29404	Lake County, IL
29820	Las Vegas-Henderson-Paradise, NV	29820	Las Vegas-Henderson-North Las Vegas, NV
31020	Longview, WA	31020	Longview-Kelso, WA
34740	Muskegon, MI	34740	Muskegon-Norton Shores, MI
34820	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	34820	Myrtle Beach-Conway-North Myrtle Beach, SC
35084	Newark, NJ-PA	35084	Newark, NJ
35154	New Brunswick-Lakewood, NJ	29484	Lakewood-New Brunswick, NJ
35840	North Port-Sarasota-Bradenton, FL	35840	North Port-Bradenton-Sarasota, FL
36084	Oakland-Berkeley-Livermore, CA	36084	Oakland-Fremont-Berkeley, CA
36260	Ogden-Clearfield, UT	36260	Ogden, UT
36540	Omaha-Council Bluffs, NE-IA	36540	Omaha, NE-IA
37460	Panama City, FL	37460	Panama City-Panama City Beach, FL
39100	Poughkeepsie-Newburgh-Middletown, NY	28880	Kiryas Joel-Poughkeepsie-Newburgh, NY
39340	Provo-Orem, UT	39340	Provo-Orem-Lehi, UT
39540	Racine, WI	39540	Racine-Mount Pleasant, WI
41540	Salisbury, MD-DE	41540	Salisbury, MD

Current CBSA Code	Current CBSA Name	Final FY 2025 CBSA Code	Final FY 2025 CBSA Name
41620	Salt Lake City, UT	41620	Salt Lake City-Murray, UT
42680	Sebastian-Vero Beach, FL	42680	Sebastian-Vero Beach-West Vero Corridor, FL
42700	Sebring-Avon Park, FL	42700	Sebring, FL
43620	Sioux Falls, SD	43620	Sioux Falls, SD-MN
44420	Staunton, VA	44420	Staunton-Stuarts Draft, VA
44700	Stockton, CA	44700	Stockton-Lodi, CA
45540	The Villages, FL	48680	Wildwood-The Villages, FL
47220	Vineland-Bridgeton, NJ	47220	Vineland, NJ
47260	Virginia Beach-Norfolk-Newport News, VA-NC	47260	Virginia Beach-Chesapeake-Norfolk, VA-NC
48140	Wausau-Weston, WI	48140	Wausau, WI
48300	Wenatchee, WA	48300	Wenatchee-East Wenatchee, WA
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	48424	West Palm Beach-Boca Raton-Delray Beach, FL
49340	Worcester, MA-CT	49340	Worcester, MA
49660	Youngstown-Warren-Boardman, OH-PA	49660	Youngstown-Warren, OH

In some cases, all the urban counties from a FY 2024 CBSA would be moved and subsumed by another CBSA in FY 2025. Table 6 lists the CBSAs that, under our proposal to adopt the revised OMB statistical area delineations, would be subsumed by another CBSA.

TABLE 6: **Urban Areas Being Subsumed By Another CBSA**

Current CBSA Code	Current CBSA Name	Final FY 2025 CBSA Code	Final FY 2025 CBSA Name
31460	Madera, CA	23420	Fresno, CA
36140	Ocean City, NJ	12100	Atlantic City-Hammonton, NJ
41900	San Germán, PR	32420	Mayagüez, PR

In other cases, if we adopt the new OMB delineations, some counties will shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. In another type of change, some CBSAs have counties that would split off to become part of or to form entirely new labor market areas. For example, the District of Columbia, DC, Charles County, MD and Prince Georges County, MD would move from CBSA 47894 (Washington-Arlington-Alexandria, D.C.-VA-MD-WV) into CBSA 47764 (Washington, D.C.-Md). Calvert County, MD

would move from CBSA 47894 (Washington-Arlington-Alexandria, D.C.-VA-MD-WV) into CBSA 30500 (Lexington Park, MD). The remaining counties that currently make up 47894 (Washington-Arlington-Alexandria, D.C.-VA-MD-WV) would move into CBSA 11694 (Arlington-Alexandria-Reston, VA-WV). Finally, in some cases, a CBSA will lose counties to another existing CBSA if we adopt the new OMB delineations. For example, Grainger County, TN would move from CBSA 34100 (Morristown, TN) into CBSA 28940 (Knoxville, TN). Table 7 lists the 73 urban counties that would move from one urban CBSA to a new or modified urban CBSA if we adopt the revised OMB delineations.

TABLE 7: Counties That Would Change to a Different Urban CBSA

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Final FY 2025 CBSA	Final FY 2025 CBSA Name
13013	BARROW	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13035	BUTTS	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13045	CARROLL	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13063	CLAYTON	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13077	COWETA	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13085	DAWSON	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13089	DE KALB	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13097	DOUGLAS	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13113	FAYETTE	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13117	FORSYTH	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13121	FULTON	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Final FY 2025 CBSA	Final FY 2025 CBSA Name
13135	GWINNETT	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13149	HEARD	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13151	HENRY	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13159	JASPER	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13199	MERIWETHER	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13211	MORGAN	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13217	NEWTON	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13227	PICKENS	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13231	PIKE	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13247	ROCKDALE	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13255	SPALDING	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13297	WALTON	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	12054	Atlanta-Sandy Springs-Roswell, GA
13015	BARTOW	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	31924	Marietta, GA
13057	CHEROKEE	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	31924	Marietta, GA
13067	COBB	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	31924	Marietta, GA
13143	HARALSON	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	31924	Marietta, GA
13223	PAULDING	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	31924	Marietta, GA

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Final FY 2025 CBSA	Final FY 2025 CBSA Name
21163	MEADE	KY	21060	Elizabethtown-Fort Knox, KY	31140	Louisville/Jefferson County, KY-IN
17097	LAKE	IL	29404	Lake County-Kenosha County, IL-WI	29404	Lake County, IL
55059	KENOSHA	WI	29404	Lake County-Kenosha County, IL-WI	28450	Kenosha, WI
06039	MADERA	CA	31460	Madera, CA	23420	Fresno, CA
47057	GRAINGER	TN	34100	Morristown, TN	28940	Knoxville, TN
37019	BRUNSWICK	NC	34820	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	48900	Wilmington, NC
22103	ST. TAMMANY	LA	35380	New Orleans-Metairie, LA	43640	Slidell-Mandeville-Covington, LA
34009	CAPE MAY	NJ	36140	Ocean City, NJ	12100	Atlantic City-Hammonton, NJ
72023	CABO ROJO	PR	41900	San Germán, PR	32420	Mayagüez, PR
72079	LAJAS	PR	41900	San Germán, PR	32420	Mayagüez, PR
72121	SABANA GRANDE	PR	41900	San Germán, PR	32420	Mayagüez, PR
72125	SAN GERMAN	PR	41900	San Germán, PR	32420	Mayagüez, PR
53061	SNOHOMISH	WA	42644	Seattle-Bellevue-Kent, WA	21794	Everett, WA
25015	HAMPSHIRE	MA	44140	Springfield, MA	11200	Amherst Town-Northampton, MA
12103	PINELLAS	FL	45300	Tampa-St. Petersburg-Clearwater, FL	41304	St. Petersburg-Clearwater-Largo, FL
12053	HERNANDO	FL	45300	Tampa-St. Petersburg-Clearwater, FL	45294	Tampa, FL
12057	HILLSBOROUGH	FL	45300	Tampa-St. Petersburg-Clearwater, FL	45294	Tampa, FL
12101	PASCO	FL	45300	Tampa-St. Petersburg-Clearwater, FL	45294	Tampa, FL
39123	OTTAWA	OH	45780	Toledo, OH	41780	Sandusky, OH
51013	ARLINGTON	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51043	CLARKE	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51047	CULPEPER	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Final FY 2025 CBSA	Final FY 2025 CBSA Name
51059	FAIRFAX	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51061	FAUQUIER	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51107	LOUDOUN	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51153	PRINCE WILLIAM	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51157	RAPPAHANNOCK	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51177	SPOTSYLVANIA	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51179	STAFFORD	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51187	WARREN	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51510	ALEXANDRIA CITY	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51600	FAIRFAX CITY	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51610	FALLS CHURCH CITY	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51630	FREDERICKSBURG CITY	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51683	MANASSAS CITY	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Final FY 2025 CBSA	Final FY 2025 CBSA Name
51685	MANASSAS PARK CITY	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
54037	JEFFERSON	WV	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
11001	THE DISTRICT	DC	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	47764	Washington, DC-MD
24017	CHARLES	MD	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	47764	Washington, DC-MD
24033	PRINCE GEORGES	MD	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	47764	Washington, DC-MD
24009	CALVERT	MD	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	30500	Lexington Park, MD
24037	ST. MARYS	MD	15680	California-Lexington Park, MD	30500	Lexington Park, MD
72059	GUAYANILLA	PR	49500	Yauco, PR	38660	Ponce, PR
72111	PENUELAS	PR	49500	Yauco, PR	38660	Ponce, PR
72153	YAUCO	PR	49500	Yauco, PR	38660	Ponce, PR

f. Transition Period

In the past we have provided for transition periods when adopting changes that have significant payment implications, particularly large negative impacts, in order to mitigate the potential impacts of proposed policies on hospices. For example, we have proposed and finalized budget-neutral transition policies to help mitigate negative impacts on hospices following the adoption of the new CBSA delineations based on the 2010 Decennial Census data in the FY 2016 hospice final rule (80 FR 47142). Specifically, we applied a blended wage index for one year (FY 2016) for all geographic areas that consisted of a 50/50 blend of the wage index values using OMB's old area delineations and the wage index values using OMB's new area delineations. That is, for each county, a blended wage index was calculated equal to 50 percent

of the FY 2016 wage index using the old labor market area delineation and 50 percent of the FY 2016 wage index using the new labor market area delineations, which resulted in an average of the two values. Additionally, in the FY 2021 hospice final rule (85 FR 47079 through 47080), we proposed and finalized a transition policy to apply a 5-percent cap on any decrease in a geographic area's wage index value from the wage index value from the prior FY. This transition allowed the effects of our adoption of the revised CBSA delineations from OMB Bulletin 18-04 to be phased in over 2 years, where the estimated reduction in a geographic area's wage index was capped at five percent in FY 2021 (that is, no cap was applied to the reduction in the wage index for the second year (FY 2022)). We explained that we believed a 5-percent cap on the overall decrease in a geographic area's wage index value would be appropriate for FY 2021, as it provided predictability in payment levels from FY 2020 to FY 2021 and additional transparency because it was administratively simpler than our prior one-year 50/50 blended wage index approach.

As discussed previously, in the FY 2023 hospice final rule, we adopted a permanent 5-percent cap on wage index decreases beginning in FY 2023 and each subsequent year (87 FR 45677). The policy applies a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline, so that a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY.

For FY 2025, we believe that the permanent 5-percent cap on wage index decreases would be sufficient to mitigate any potential negative impact for hospices serving beneficiaries in areas that are impacted by the proposal to adopt the revised OMB delineations and that no further transition is necessary. Previously, the 5-percent cap had been applied at the CBSA or statewide rural area level, meaning that all the counties that make up the CBSA or rural area received the 5-percent cap. However, for FY 2025, to mitigate any potential negative impact caused by our proposed adoption of the revised delineations, we proposed that in addition to the

5-percent cap being calculated for an entire CBSA or statewide rural area the cap would also be calculated at the county level, so that individual counties moving to a new delineation would not experience more than a 5 percent decrease in wage index from the previous fiscal year. Specifically, we proposed for FY 2025, that the 5-percent cap would also be applied to counties that move from a CBSA or statewide rural area with a higher wage index value into a new CBSA or rural area with a lower wage index value, so that the county's FY 2025 wage index would not be less than 95 percent of the county's FY 2024 wage index value under the old delineation despite moving into a new delineation with a lower wage index.

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

Therefore, hospices that serve beneficiaries in a county that would receive the cap would need to use a number other than the CBSA or statewide rural area number to identify the county's appropriate wage index value for hospice claims in FY 2025. We proposed that beginning in FY 2025, counties that have a different wage index value than the CBSA or rural area into which they are designated due to the application of the 5-percent cap would use a wage index transition code. These special codes are five digits in length and begin with "50." The 50XXX wage index transition codes would be used only in specific counties; counties located in CBSAs and rural areas that do not correspond to a different transition wage index value will still use the CBSA number. For example, FIPS county 13171 Lamar County, GA is currently part of

CBSA 12060 Atlanta-Sandy Springs-Alpharetta. However, for FY 2025 we proposed that Lamar County would be redesignated into the Rural Georgia Code 99911. Because the wage index value of rural Georgia is more than a 5-percent decrease from the wage index value that Lamar County previously received under CBSA 12060, the FY 2025 wage index for Lamar County would be capped at 95 percent of the FY 2024 wage index value for CBSA 12060. Additionally, because rural Georgia can only have one wage index value assigned to code 99911, in order for Lamar County to receive the capped wage index for FY 2025, transition code 50002 would be used instead of rural Georgia code 99911.

Table 8 includes a list of counties that have changed designation and must use a transition code beginning in FY 2025. This list is comprised of counties that are redesignated into a new CBSA or rural area and will receive the 5-percent cap on wage index decreases. These counties must use a transition code because the wage index for that county is higher than all other constituent counties that make up the CBSA or rural area (like the example above for Lamar County, GA.) Additionally, the list also includes counties that move into a new CBSA or rural area and have a different wage index value because the constituent counties that make up the CBSA or rural receive the 5-percent cap for FY 2025 while the county that moves into the CBSA or rural area does not. For example, rural area 99922 rural Massachusetts is comprised of FIPS code 25007 Dukes County, FIPS code 25019 Nantucket County and the redesignated FIPS code 25011 Franklin County. Dukes County and Nantucket County were part of rural area 99922 Massachusetts for FY 2024 and will receive the 5-percent cap because the FY 2025 wage index for rural area 99922 is more than a 5-percent decrease from the FY 2024 wage index for rural area 99922. However, Franklin County was included in CBSA 44140 Springfield, MA in FY 2024 and the uncapped FY 2025 wage index for rural area 99922 is higher than the FY 2024 wage index for CBSA 44140. In this example, Franklin County, MA would receive the uncapped wage index for rural Area 99922 while Dukes and Nantucket counties receive the 5-

percent capped wage index. Therefore, hospices that serve beneficiaries in Franklin County, MA must use the transition code 50010 on hospice claims.

Additionally, we proposed that the 5-percent cap would apply to a county that corresponds to a different wage index value than the wage index value in the CBSA or rural area in which they are designated due to a delineation change until the county's new wage index is more than 95 percent of the wage index from the previous fiscal year. We also proposed that in order to capture the correct wage index value, the county would continue to use the assigned 50XXX transition code until the county's wage index value calculated for that fiscal year using the new OMB delineations is not less than 95 percent of the county's capped wage index from the previous fiscal year. Thus, in the example mentioned previously, Lamar County would continue to use transition code 50002 until the wage index in its revised designation of Rural Georgia is equal to or more than 95 percent of its wage index value from the previous fiscal year. The counties that will require a transition code in FY 2025 and the corresponding 50XXX codes are shown in Table 8 and will also be shown in the last column of the FY 2025 hospice wage index file.

TABLE 8: Counties That Will Use a Wage Index Transition Code

FIPS Code	County Name	FY 2024 CBSA	FY 2024 CBSA Name	FY 2025 CBSA	FY 2025 CBSA NAME	Transition Code
01129	WASHINGTON	33660	Mobile, AL	99901	ALABAMA	50001
13171	LAMAR	12060	Atlanta-Sandy Springs-Alpharetta, GA	99911	GEORGIA	50002
15005	KALAWAO	99912	HAWAII	27980	Kahului-Wailuku, HI	50003
16077	POWER	38540	Pocatello, ID	99913	IDAHO	50004
17183	VERMILION	19180	Danville, IL	99914	ILLINOIS	50005
18133	PUTNAM	26900	Indianapolis-Carmel-Anderson, IN	99915	INDIANA	50006
21101	HENDERSON	21780	Evansville, IN-KY	99918	KENTUCKY	50007
24009	CALVERT	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	30500	Lexington Park, MD	50008
24047	WORCESTER	41540	Salisbury, MD-DE	99921	MARYLAND	50009
25011	FRANKLIN	44140	Springfield, MA	99922	MASSACHUSETTS	50010
26155	SHIAWASSEE	29620	Lansing-East Lansing, MI	99923	MICHIGAN	50011
27075	LAKE	20260	Duluth, MN-WI	99924	MINNESOTA	50012

27133	ROCK	99924	MINNESOTA	43620	Sioux Falls, SD-MN	50013
32019	LYON	99929	NEVADA	39900	Reno, NV	50014
34009	CAPE MAY	36140	Ocean City, NJ	12100	Atlantic City-Hammonton, NJ	50015
36123	YATES	40380	Rochester, NY	99933	NEW YORK	50016
37077	GRANVILLE	20500	Durham-Chapel Hill, NC	99934	NORTH CAROLINA	50017
37087	HAYWOOD	11700	Asheville, NC	99934	NORTH CAROLINA	50018
39123	OTTAWA	45780	Toledo, OH	41780	Sandusky, OH	50019
42103	PIKE	35084	Newark, NJ-PA	99939	PENNSYLVANIA	50020
51113	MADISON	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	99949	VIRGINIA	50021
51175	SOUTHAMPTON	47260	Virginia Beach-Norfolk-Newport News, VA-NC	99949	VIRGINIA	50022
51620	FRANKLIN CITY	47260	Virginia Beach-Norfolk-Newport News, VA-NC	99949	VIRGINIA	50022
54057	MINERAL	19060	Cumberland, MD-WV	99951	WEST VIRGINIA	50023
72001	ADJUNTAS	38660	Ponce, PR	99940	PUERTO RICO	50024
72023	CABO ROJO	41900	San Germ n, PR	32420	Mayagüez, PR	50025
72055	GUANICA	49500	Yauco, PR	99940	PUERTO RICO	50026
72059	GUAYANILLA	49500	Yauco, PR	38660	Ponce, PR	50027
72079	LAJAS	41900	San Germán, PR	32420	Mayagüez, PR	50025
72081	LARES	10380	Aguadilla-Isabela, PR	99940	PUERTO RICO	50028
72083	LAS MARIAS	32420	Mayagüez, PR	99940	PUERTO RICO	50029
72111	PENUELAS	49500	Yauco, PR	38660	Ponce, PR	50027
72121	SABANA GRANDE	41900	San Germán, PR	32420	Mayagüez, PR	50025
72125	SAN GERMAN	41900	San Germán, PR	32420	Mayagüez, PR	50025
72141	UTUADO	10380	Aguadilla-Isabela, PR	99940	PUERTO RICO	50028
72153	YAUCO	49500	Yauco, PR	38660	Ponce, PR	50027

We received 11 comments on our proposal to adopt the latest OMB delineations from OMB Bulletin No. 23-01 (and the resulting changes) with the permanent 5-percent cap as a transition. The following is a summary of these comments and our responses to those comments.

Comment: Most commenters stated that they support the adoption of the revised OMB delineations from the July 21, 2023, Bulletin No. 23-01. Most commenters also expressed support for the use of the permanent 5-percent cap policy as a transition to the policy.

Response: We appreciate the commenters' support of the adoption of the new OMB delineations and the use of the permanent 5-percent cap as a transition.

Comment: A few commenters opposed our proposal to adopt the new delineations. One commenter from Montgomery County, MD, expressed concern that the revised delineations fail

to resolve the issue of the county being excluded from the Washington, D.C. CBSA. Other commenters stated that the adoption of the revised OMB delineations would result in a reduction in reimbursement for counties in states such as California, Illinois, and New York. One commenter suggested that the proposed updates to CBSAs based on the 2020 Decennial Census will not only eliminate any proposed rate increase but will reduce reimbursement in thirty-three percent of New York's sixty-one counties.

Response: We appreciate the concerns commenters raised regarding the impact of implementing the revised designations on their specific counties. While we understand the concern regarding the potential financial impact, we believe that implementing the revised OMB delineations will create more accurate representations of labor market areas nationally and result in hospice wage index values being more representative of the actual costs of labor in a given area. Although these comments only addressed any negative impacts on specific geographic areas, we believe it is important to note that there are many geographic locations and hospice providers that will experience positive impacts upon implementation of the revised CBSA designations. We believe that the OMB delineations for Metropolitan and Micropolitan Statistical Areas are appropriate for use in accounting for wage area differences and that the values computed under the revised delineations will result in more appropriate payments to providers by more accurately accounting for and reflecting the differences in area wage levels. We also recognize that there are areas which will experience a decrease in their wage index. As such, it is our longstanding policy to provide temporary adjustments to mitigate negative impacts from the adoption of new policies or procedures. In the FY 2025 Hospice Wage Index and Payment Rate Update proposed rule, we proposed to use the finalized 5-percent cap policy as a transition in order to mitigate the resulting short-term instability and negative impacts on certain providers. We continue to believe that the finalized 5-percent cap policy provides an adequate safeguard against any significant payment reductions, allows for sufficient time to make operational changes for future fiscal years, and provides a reasonable balance between mitigating

some short-term instability in hospice payments and improving the accuracy of the payment adjustment for differences in area wage levels.

Comment: A few commenters, including MedPAC, suggested alternatives to the 5-percent cap transition policy. MedPAC suggested that the 5-percent cap limit should apply to both increases and decreases in the wage index so that no provider would have its wage index value increase or decrease by more than 5 percent. However, several commenters recommended lowering the finalized 5-percent cap on wage index decreases (for example, a 2-percent cap was recommended). These commenters stated that capping decreases at 5 percent is insufficient to mitigate negative impacts faced by hospices. One commenter stated that while the permanent maximum drop in wage index values is appreciated, even a 5 percent drop in rates from one year to the next in this inflationary time is very difficult. Another commenter recommended that CMS limit the maximum wage index reduction to a percentage equal to or less than the payment update for that year. This commenter also suggested that CMS change the policy so that there is no reduction in wage index values but instead only increases. One commenter recommended the wage index cap be lowered for FY 2025 as a transition to the adoption of the revised delineations. Two commenters requested that CMS institute a one-time zero wage index adjustment in all CBSAs where there is a negative adjustment.

Response: We appreciate the commenters' recommendations for changes to the finalized cap policy. Regarding MedPAC's suggestion that the cap on wage index changes of more than 5 percent should also be applied to wage index increases, as we discussed previously, the purpose of the finalized 5-percent cap policy is to help mitigate the significant negative impacts of certain wage index changes. Additionally, we believe that the 5-percent cap on wage index decreases is an adequate safeguard against any significant payment reductions and do not believe that capping wage index decreases at 2 percent instead of 5 percent is appropriate. We also do not believe it would be appropriate to institute a one-time zero wage index adjustment or implement a policy where there are no wage index decreases. We continue to believe that a 5-percent cap

would more effectively mitigate any significant decreases in a hospice's wage index for a fiscal year, while still balancing the importance of ensuring that area wage index values accurately reflect relative differences in area wage levels. Furthermore, a 5-percent cap on wage index decreases provides a degree of predictability in payment changes for providers and allows providers time to adjust to any significant decreases they may face year to year.

Final Decision: We are finalizing our proposal to adopt the revised OMB delineations from the July 21, 2018 OMB Bulletin 23–01, and will also apply the permanent 5-percent cap on wage index decreases at the county level with the use of a transition code, so that counties impacted by the revised designations will receive a 5-percent cap on any decrease in a geographic area's wage index value from the wage index value from the prior fiscal year for FY 2025. We are also finalizing that beginning in FY 2025, counties that have a different wage index value than the CBSA or rural area into which they are designated due to the application of the 5-percent cap (including redesignated counties that will receive the 5-percent cap and redesignated counties that move into a CBSA or rural area where all other constituent counties receive the 5-percent cap) would use a wage index transition code. These special codes are five digits in length and begin with "50." The 50XXX wage index transition codes will be used only in specific counties; counties located in CBSAs and rural areas that do not correspond to a different transition wage index value will still use the CBSA number. Finally, we are finalizing the policy that the 5-percent cap will apply to a county that corresponds to a different wage index value than the wage index value in the CBSA or rural area in which they are designated due to a delineation change until the county's new wage index is more than 95 percent of the wage index from the previous fiscal year. In order to capture the correct wage index value, the county will continue to use the assigned 50XXX transition code until the county's wage index value calculated for that fiscal year using the new OMB delineations is not less than 95 percent of the county's capped wage index from the previous fiscal year.

The final FY 2025 wage index file provides a crosswalk between the current OMB delineations and the final revised OMB delineations that will be in effect in FY 2025. This file shows each State and county and its corresponding final wage index along with the previous CBSA number, the final CBSA number or alternate identification number, and the final CBSA name. The final hospice wage index file applicable for FY 2025 (October 1, 2024 through September 30, 2025) is available on the CMS website at: https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-wage-index.

3. FY 2025 Hospice Payment Update Percentage

Section 4441(a) of the Balanced Budget Act of 1997 (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 one percentage point. Payment rates for FYs since 2002 have been updated as required by section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient hospital market basket percentage increase for that FY. In the FY 2022 IPPS final rule, we finalized the rebased and revised IPPS market basket to reflect a 2018 base year. We refer readers to the FY 2022 IPPS final rule (86 FR 45194) for further information.

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period (the "productivity adjustment"). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the

United States economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021, release of productivity data, BLS replaced the term "multifactor productivity" with "total factor productivity" (TFP). BLS noted that this is a change in terminology only and would not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as "private nonfarm business total factor productivity." However, as mentioned, the data and methods are unchanged. We refer readers to http://www.bls.gov for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-research-and-information. In addition, in the FY 2022 IPPS final rule (86 FR 45214), we noted that beginning with FY 2022, CMS changed the name of this adjustment to refer to it as the "productivity adjustment" rather than the "MFP adjustment". Consistent with our historical practice, we estimate the market basket percentage increase and the productivity adjustment based on IHS Global Inc.'s (IGI's) forecast using the most recent available data. The proposed hospice payment update percentage for FY 2025 was based on the most recent estimate of the inpatient hospital market basket (based on IGI's fourth quarter 2023 forecast with historical data through the third quarter of 2023). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the proposed inpatient hospital market basket percentage increase for FY 2025 of 3.0 percent is required to be reduced by a productivity adjustment as mandated by section 3401(g) of the Affordable Care Act. The proposed productivity adjustment for FY 2025 was 0.4 percentage point (based on IGI's fourth quarter 2023 forecast). Therefore, the proposed hospice payment update percentage for FY 2025 was 2.6 percent. We also proposed that if more recent data became available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the inpatient hospital market

basket percentage increase or productivity adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage in the FY 2025 final rule. We continue to believe it is appropriate to routinely update the hospice payment system so that it reflects the best available data about differences in patient resource use and costs among hospices as required by the statute.

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

We received 45 comments on the proposed hospice update percentage of 2.6 percent. A summary of the comments and our responses to those comments are as follows:

Comment: A couple of commenters stated appreciation for the proposed hospice market basket update for FY 2025; however, most commenters stated that the proposed 2.6 percent increase does not cover the increased operating costs they have faced throughout the pandemic. The commenters requested CMS determine whether additional updates could be made during FY 2025.

Specifically, the commenters stated that they have been facing unprecedented increases in labor costs, particularly for nursing staff and that labor accounts for a large percentage of their operating costs, more so than other provider types. Additionally, several commenters noted that the healthcare worker shortages exacerbate wage pressure increases. For example, a few commenters stated that their compensation costs account for approximately 80 percent of the overall operating costs. Several commenters stated that they have experienced increased expenses for employed nursing staff, therapy staff, and ancillary staff. Many commenters noted

the difficulty in recruiting and retaining staff, as other provider types can pay higher wages. One commenter stated that New York State Medicaid recognized the catastrophic impact of rising healthcare costs and approved a rate increase of 3.5 percent, acknowledging the higher cost of doing business in New York, which was partly driven by the largest wage increase in New York City's public sector nursing history. One industry association stated that their members reported that workforce shortages are their biggest challenge.

The commenters also stated that the proposed payment update does not appropriately capture the inflation pressures experienced for non-labor operating expenses, specifically the increased costs for medical supplies, pharmaceuticals, materials, and utilities. One commenter stated that their total drug expenses per hospice day are 14 percent higher and medical supply costs and staff travel reimbursement (as staff travel to patient homes to provide care) have increased 4 percent and 6.5 percent, respectively, over the past year. The commenters stated that it has been difficult to budget wage increases in order to attract and retain staff while at the same time covering higher input costs for other operating expenses.

Several commenters explicitly noted that the proposed 2.6 percent increase in hospice payments is less than the current rate of U.S. inflation as measured by the Consumer Price Index for All Urban Consumers (CPI-U) which they state increased by 3.4 percent year-over-year in April 2024, nearly a percent higher than the proposed FY 2025 hospice update of 2.6 percent. One commenter also noted that the proposed update is below the 3.7 percent increase for Medicare Advantage plans. Several commenters stated that unlike other Medicare provider types, like hospitals, most hospice care is financed predominantly by Medicare and Medicaid and as a result, hospice providers are unable to shift costs to other payers to help offset losses.

MedPAC recognized that CMS is required by statute to propose an increase to the hospice payment rates; however, the Commission recommended eliminating the update for FY 2025. The Commission referenced their March 2024 Report to the Congress and that their assessment of indicators of payment adequacy for hospices—beneficiary access to care, quality

of care, provider access to capital, and Medicare payments relative to providers' costs—were positive. Additionally, MedPAC noted that hospice Medicare profit margins were between 13 to 17 percent in aggregate.

Response: We appreciate the commenters' support for the statutorily required hospice payment update and reiterate that we are required to update hospice payments by the IPPS market basket update adjusted for productivity, as directed by section 1814(i)(1)(C)(ii)(VII) of the Act. We believe the increase in the 2018-based IPPS operating market basket adequately reflects the average change in the price of goods and services hospitals purchase in order to provide medical services. The IPPS market basket is a fixed-weight, Laspeyres-type index that measures price changes over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services. As such, the IPPS market basket update would reflect the prospective price pressures described by the commenters during a high inflation period (such as faster wage growth or higher energy prices) but might not reflect other factors that could increase costs such as the quantity of labor used or any shifts between contract and staff nurses. We note that cost changes (that is, the product of price and quantities) would only be reflected when a market basket is rebased, and the base year weights are updated to a more recent time period.

We agree with the commenters that recent higher inflationary trends have impacted the outlook for price growth over the pandemic period. However, the purpose of the FY 2025 hospice payment update is to reflect the price pressures providers are expected to face in FY 2025, and thus is a forward-looking update as opposed to one that reflects historical price changes. At the time of the FY 2025 hospice PPS proposed rule, based on IGI's fourth quarter 2023 forecast with historical data through third quarter 2023, IGI forecasted the 2018-based IPPS market basket update of 3.0 percent for FY 2025 reflecting a 3.6-percent forecasted compensation price increase. We would note that the 10-year historical average (2014-2023) growth rate of the 2018-based IPPS market basket is 2.8 percent with compensation prices

increasing 2.8 percent. We stated in the FY 2025 hospice PPS proposed rule (89 FR 23800) that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2025 hospice payment update percentage for the final rule. For this final rule, we are using an updated forecast of the price proxies underlying the 2018-based IPPS market basket that incorporates more recent historical data and reflects a revised outlook regarding the U.S. economy, including compensation and inflationary pressures. Based on IGI's second quarter 2024 forecast with historical data through first quarter 2024, the FY 2025 IPPS market basket update is 3.4 percent (reflecting forecasted compensation price growth of 3.9 percent). The FY 2025 productivity adjustment based on IGI's second quarter 2024 forecast is 0.5 percentage point. Therefore, as discussed further in this section and after consideration of the comments received, for FY 2025, the final hospice payment update is 2.9 percent (3.4 percent market basket percentage increase less a 0.5 percentage point productivity adjustment), compared to the proposed hospice payment update of 2.6 percent. Finally, we believe the FY 2025 hospice payment update to be adequate based on the MedPAC analysis that showed positive payment indicators of beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers' costs.

Comment: Many commenters stated that there have been 3 years of under forecasted payment rate updates. The commenters noted that the market basket forecast for FY 2021 through FY 2023 was cumulatively under forecast by 4.6 percentage points over those 3 years and requested a one-time retrospective adjustment to rectify the significant forecast error since 2021. The commenters stated that they understand that the market basket updates are based on a forecast of projected inflation; however, they also stated that multiple years in a row of significantly under forecast updates is not sustainable and has impaired hospices' capacity to serve their beneficiary communities. Several commenters also acknowledged that while the adjustment can be applied positively or negatively, the update for the last 3 years was consistently and significantly under forecast. A few commenters pointed to the public data from

the CMS Office of the Actuary, which show the actual forecast error. Finally, commenters noted that the inadequacy of this payment update is further compounded by continued sequestration, which reduces Medicare payments by two percent and is currently set to continue through FY 2032. Many commenters requested a retrospective adjustment be finalized to account for the significant forecast error since 2021.

Several commenters highlighted that the CMS response to a similar concern in the FY 2024 rule stated that CMS lacks the statutory authority to implement an adjustment; however, the commenters requested that CMS provide additional information and a specific explanation supporting that it lacks the statutory authority to apply an adjustment using the special exceptions and adjustment authority. Several commenters also stated that there exists a precedent for CMS to adjust for forecast errors in the market basket updates, as was previously implemented in a SNF PPS update, which finalized a 3.6 percent forecast error adjustment in the FY 2024 SNF PPS final rule (88 FR 53205 through 53206). One commenter stated the cumulative forecast error of hospital market basket updates was below both the growth in the Employment Cost Index (ECI) total compensation index and the Producer Price Index (PPI) – All Commodities Index. One commenter requested that CMS impose an additional 3 percent payment adjustment at a minimum even if the full cumulative forecast error adjustment is not possible.

Several commenters stated that if CMS is limited by statute to implement a forecast error adjustment for updating hospice payments that CMS work with Congress to include funding for a one-time market basket forecast error adjustment for hospice providers as a component of any end of year legislation taken up by the 118th Congress.

Response: We thank the commenters for their recommendations. The inpatient hospital market basket percentage increases are required by law to be set prospectively, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. There is currently no mechanism to adjust for market basket forecast error in the hospice payment update. Furthermore, beginning in 1989, the

Congress gave hospices their first increase (20 percent) in payment since 1986 and tied future increases to the annual increase in the hospital market basket through a provision contained in the Omnibus Budget Reconciliation Act of 1989. While the projected inpatient hospital market basket percentage increases for FY 2021, FY 2022, and FY 2023 were under forecast, this was largely due to unanticipated inflationary and labor market pressures as the economy emerged from the COVID–19 PHE. Importantly, the hospital market basket has been used for many years to update hospice payment rates and an analysis of the forecast error over a longer period of time shows that the forecast error has been both positive and negative. For example, the 10-year cumulative forecast error (excluding FY 2018 when the hospice payment update was statutorily required to be 1.0 percent) was slightly positive, equal to 0.2 percentage point (2014–2023). Each year from 2014 through 2020, the final FY hospital market basket update was higher than the actual hospital market basket update once historical data was finalized; with (5 out of the 7 years between 2014 to 2020 having a forecast error greater than 0.5 percentage point.). Only considering the forecast error for years when the final inpatient hospital market basket percentage increase was lower than the actual inpatient hospital market basket percentage increase does not consider the numerous years that providers benefited from the forecast error. CMS understands that the market basket updates may differ from other overall inflation indexes such as the topline ECI, CPI, or PPI; however, we would reiterate that comparisons between these topline indexes are not comparable since they measure different mixes of products, services, or wages than reflected in the legislatively defined CMS IPPS hospital market basket.

Comment: One commenter stated they have repeatedly shared concerns with CMS on the quality of cost report data, especially with regards to capturing actual labor costs, and that cost reports should be improved and optimized before they are used for payment purposes. The commenter recommends that the cost reports be amended to allow for a greater breakdown of costs for contracted versus hospice-administered inpatient services to apportion the labor share appropriately. They further requested that CMS clarify how frequently they intend to update the

labor share component moving forward and clarify the development and methodology around the "standardization factor." This includes clarification as to how CMS will adjust the labor share if certain types of hospices are found to provide more services and thus, are likely to have a larger labor share but contribute fewer cost reports. Lastly the commenter recommended that the definition of a "day" be any 24-hour period or that CMS create a modifier to allow hospices to bill into a second day up to a 24-hour limit.

Response: We appreciate the commenter's request for future changes to the hospice cost report. The labor shares for other PPS systems (for example, IPPS and HHA) are typically updated every 4 to 5 years. As stated in the FY 2022 hospice final rule (86 FR 42533 through 42534), we tentatively plan to rebase the hospice labor shares on a similar schedule as the other payment systems under Medicare. However, in light of the COVID–19 Public Health Emergency (PHE), we plan to monitor the upcoming Medicare cost report data to see if more frequent revision of the hospice labor shares is necessary in order to reflect more recent cost structures of hospice providers. Given that the COVID-19 PHE continued into 2023, we have only been able to conduct preliminary analysis of 2021 and 2022 Medicare cost report data as the 2023 Medicare cost report data are not yet available. Therefore, in the FY 2025 hospice proposed rule, we did not propose to rebase the hospice labor shares because of this incomplete data. We will continue to monitor these data and any future revisions to the hospice labor shares will be proposed and subject to public comments in future rulemaking.

Comment: One commenter stated that the updated hospice wage index should reflect the competitive nature of the healthcare job market and include substantial increases in hourly rates for hospice registered nurses, certified nursing assistants, and support staff. They further stated that the Bureau of Labor Statistics reports that a hospice nurse earns an average of $32.10 per hour while the average for nurses in all other settings is $39.05 per hour. They noted that vacancy rates for registered nurses and licensed practical nurses is averaging as high as 20

percent in some states. They stated that this issue can be solved by increasing the payment rate of hospice workers through the update of this rule.

Response: We appreciate the commenter's concerns regarding labor wage rates. Hospice payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which provides that the update to the payment rates for subsequent FYs must be the inpatient hospital market basket percentage increase for that FY. Additionally, as mandated by section 3401(g) of the Affordable Care Act, the inpatient hospital market basket percentage increase is required to be reduced by a productivity adjustment. The inpatient hospital market basket percentage increase reflects the projected wage inflation for healthcare and non-health care workers employed in hospitals (as measured by the Employment Cost Index (ECI) for wages and salaries for hospital workers). As stated in the FY 2025 hospice proposed rule (89 FR 23800), we estimated the market basket percentage increase and the productivity adjustment based on IHS Global Inc.'s (IGI's) forecast using the most recent available data. IGI is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the price proxies of the market baskets. The proposed inpatient hospital market basket percentage increase for FY 2025 was 3.0 percent reflecting compensation prices increasing 3.6 percent. When developing its forecasts for the ECI for wages and salaries and employee benefits for hospital workers, IHS Global Inc. considers the overall competitive nature of labor market conditions. We would note that the 10-year historical average (2014-2023) growth rate of the 2018-based IPPS market basket is 2.8 percent with compensation prices increasing 2.8 percent. As also stated in the FY 2025 hospice proposed rule (89 FR 23800), we stated that if more recent data became available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the inpatient hospital market basket percentage increase or productivity adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage in the FY 2025 final rule.

Final Decision: We are finalizing the hospice payment update using the methodology outlined. For this final rule, based on the more recent IGI second quarter 2024 forecast with historical data through the first quarter of 2024 the 2018-based IPPS market basket increase factor for FY 2025 is 3.4 percent. The FY 2025 productivity adjustment based on the more recent IGI second quarter 2024 forecast is 0.5 percentage point. Therefore, CMS is finalizing for FY 2025, a hospice payment update of 2.9 percent (3.4 percent market basket percentage increase less a 0.5 percentage point productivity adjustment).

4. FY 2025 Hospice Payment Rates

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

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 61 and beyond. In addition, in that final rule, we implemented a Service Intensity Add-On (SIA) payment for RHC when direct patient care is provided by a registered nurse (RN) or social worker during the last seven 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 four hours total) that occurred on the day of service if certain criteria are met. To maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by an SIA 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. For FY 2025, the proposed SIA budget neutrality factor is 1.009 for RHC days 1-60 and 1.000 for RHC days 61+.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. For FY 2025 hospice rate setting, we are continuing our longstanding policy of using the most recent data available. Specifically, we proposed to use FY 2023 claims data as of January 11, 2024 for the FY 2025 payment rate updates. We noted that the budget neutrality factors and payment rates would be updated with more complete FY 2023 claims data for the final rule. In order to calculate the wage index standardization factor, we simulate total payments using FY 2023 hospice utilization claims data with the FY 2024 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, old OMB delineations, and the 5-percent cap on wage index decreases) and FY 2024 payment rates and compare it to our simulation of total payments using FY 2023 utilization claims data, the final FY 2025 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the revised OMB delineations, with the 5-percent cap on wage index decreases) and FY 2024 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2024 wage index and FY 2024 payment rates for each level of care by the FY 2025 wage index and FY 2024 payment rates, we obtain a wage index standardization factor for each level of care. The wage index standardization factors for each level of care are shown in Tables 1 and 2.

The final FY 2025 RHC rates are shown in Table 9. The final FY 2025 payment rates for CHC, IRC, and GIP are shown in Table 10.

TABLE 9: Final FY 2025 Hospice RHC Payment Rates-

Code	Description	FY 2024 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2025 Hospice Payment Update	FY 2025 Payment Rates
651	**Routine Home Care (days 1-60)**	$218.33	1.0014	0.9984	1.029	$224.62
651	**Routine Home Care (days 61+)**	$172.35	1.0001	0.9975	1.029	$176.92

TABLE 10: Final FY 2025 Hospice CHC, IRC, and GIP Payment Rates-

Code	Description	FY 2024 Payment Rates	Wage Index Standardization Factor	FY 2025 Hospice Payment Update	FY 2025 Payment Rates
652	**Continuous Home Care Full Rate = 24 hours of care.**	$1,565.46	1.0048	1.029	$1,618.59 ($67.44 per hour)
655	**Inpatient Respite Care**	$507.71	0.9930	1.029	$518.78
656	**General Inpatient Care**	$1,145.31	0.9928	1.029	$1,170.04

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data 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 Hospice Quality Reporting Program (HQRP) as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the Consolidated Appropriations Act (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. Depending on the amount of the annual update for a particular year, a reduction of 4 percentage points beginning in FY 2024 makes a negative payment update more likely than the previous 2 percent reduction. This 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. We applied this policy beginning with the FY 2024 Annual Payment Update (APU), which we based on CY 2022 quality data. Therefore, the final FY 2025 rates for hospices that do not submit the required quality data would be updated by -1.1 percent, which is the final FY 2025 hospice payment update percentage of 2.9 percent minus four percentage points. Using updated data, these final rates are shown in Tables 11 and 12.

TABLE 11: Final FY 2025 Hospice RHC Payment Rates for Hospices That <u>DO NOT</u> Submit the Required Quality Data

Code	Description	FY 2024 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2025 Hospice Payment Update of 2.9% minus 4 percentage points = -1.1%	FY 2025 Payment Rates
651	**Routine Home Care (days 1-60)**	$218.33	1.0014	0.9984	0.9890	$215.88
651	**Routine Home Care (days 61+)**	$172.35	1.0001	0.9975	0.9890	$170.05

TABLE 12: Final FY 2025 Hospice CHC, IRC, and GIP Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2024 Payment Rates	Wage Index Standardization Factor	FY 2025 Hospice Payment Update of 2.9% minus 4 percentage points = -1.1%	FY 2025 Payment Rates
652	**Continuous Home Care Full Rate = 24 hours of care.**	$1,565.46	1.0048	0.9890	$1,555.67 (64.82 per hour)
655	**Inpatient Respite Care**	$507.71	0.9930	0.9890	$498.61
656	**General Inpatient Care**	$1,145.31	0.9928	0.9890	$1,124.56

5. Hospice Cap Amount for FY 2025

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, Oct. 6, 2014). Specifically, we stated that for accounting years that end after September 30, 2016, and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. Division CC, section 404 of the CAA, 2021 extended the accounting years impacted by the adjustment made to the hospice cap calculation until 2030. In the FY 2022 Hospice Wage Index final rule (86 FR 42539), we finalized conforming regulations text changes at § 418.309 to reflect the provisions of the CAA, 2021. Division P, section 312 of the CAA, 2022 (Pub. L. 117-103) amended section 1814(i)(2)(B) of the Act and extended the provision that mandates the hospice cap be updated by the hospice payment update percentage (the inpatient hospital market basket percentage increase reduced by the productivity adjustment) rather than the CPI-U for accounting years that end after September 30, 2016 and before October 1, 2031. Division FF, section 4162 of the CAA, 2023 (Pub. L. 118-328) 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 (the inpatient hospital market basket percentage increase reduced by the productivity adjustment)

rather than the CPI-U for accounting years that end after September 30, 2016 and before October 1, 2032. Division G, Section 308 of the Consolidated Appropriations Act, 2024 (CAA, 2024) (Pub. L. 118-42) extends this provision to October 1, 2033. Before the enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI-U beginning on October 1, 2032. Therefore, for accounting years that end after September 30, 2016, and before October 1, 2033, the hospice cap amount is updated by the hospice payment update percentage rather than the CPI-U. As a result of the changes mandated by the CAA, 2024, we proposed conforming regulation text changes at § 418.309 to reflect the revisions at section 1814(i)(2)(B) of the Act.

The proposed hospice cap amount for the FY 2025 cap year was $34,364.85, which is equal to the FY 2024 cap amount ($33,494.01) updated by the proposed FY 2025 hospice payment update percentage of 2.6 percent. We also proposed that if more recent data became available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the hospice payment update percentage), we would use such data, if appropriate, to determine the hospice cap amount in the FY 2025 final rule. As such, the hospice cap amount for the FY 2025 cap year is $34,465.34, which is equal to the FY 2024 cap amount ($33,494.01) updated by the FY 2025 hospice payment update percentage of 2.9 percent.

We received 3 comments on the proposed hospice cap. The following is a summary of these comments and our responses:

Comment: One commenter expressed support for the FY 2025 hospice cap.

Response: We thank the commenter for their support.

Comment: Two commenters opposed an increase to the hospice cap. One commenter recommended the cap remain at the FY 2024 level of $33,494.01 and one commenter recommended that the cap be lowered for FY 2025.

Response: We thank the commenters for their recommendations to improve the hospice cap; however, we are required by law to update the hospice cap amount from the preceding year by the hospice payment update percentage, in accordance with section 1814(i)(2)(B)(ii) of the Act.

Final Decision: We are finalizing the update to the hospice cap amount for FY 2025 in accordance with statutorily mandated requirements and adopting the proposed regulation text change at § 418.309 to reflect the revisions at section 1814(i)(2)(B) of the Act, which require that, for accounting years that end after September 30, 2016, and before October 1, 2033, the hospice cap amount be updated by the hospice payment update percentage rather than the CPI-U.

B. Clarifying Regulation Text Changes and Technical Edit

1. Medical Director Condition of Participation

CMS has broad statutory authority to establish health and safety standards for most Medicare- and Medicaid-participating provider and supplier types. The Secretary gives CMS the authority to enact regulations that are in the interest of the health and safety of individuals who are furnished services in an institution, while other laws, as outlined below, give CMS the authority to prescribe regulations as may be necessary to carry out the administration of the program. Section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97-248) added section 1861(dd) to the Act to provide coverage for hospice care to terminally ill Medicare beneficiaries who elect to receive care from a Medicare-participating hospice. The CoPs apply to the hospice as an entity, as well as to the services furnished to each individual patient under hospice care. In accordance with section 1861(dd) of the Act, the Secretary is responsible for ensuring that the CoPs are adequate to protect the health and safety of the individuals under hospice care.

Based on feedback from interested parties, including hospice providers, national hospice associations, and accrediting organizations, we identified discrepancies between the Medical Director CoP at § 418.102 and the payment requirements for the "certification of the terminal

illness" and the "admission to hospice care" at § 418.22 and § 418.25, respectively. Specifically, the industry questioned the language in the requirements as it relates to medical directors in the CoPs, physician designees in the CoPs, and physician members of the interdisciplinary group (IDG) in the payment requirements. Currently, the medical director provisions in the CoPs at §§ 418.102(b) and (c) require the medical director or physician designee to review the clinical information for each patient and provide written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. However, the statutory requirements in sections 1814(a)(7)(A)(i)(II) and (ii) of the Act and the regulatory payment requirements at § 418.22 (*Certification of terminal illness*) provide that the medical director of the hospice or the physician member of the hospice interdisciplinary group can certify the patient's terminal illness. Although the CoP provisions at §§ 418.102(b) and (c) include requirements for the initial certification and recertification of terminal illness, they do not include the physician member of the interdisciplinary group among the types of practitioners who can provide these certifications, even though these physicians are able to certify terminal illness under the payment regulation at § 418.22 (*Certification of terminal illness*).

This misalignment between the CoPs and the payment requirements has caused some confusion for hospice providers, accrediting bodies, and surveyors. As a result, we determined that conforming changes to the medical director CoP were appropriate for clarity and consistency. To align the medical director CoP and the hospice payment requirements, we proposed to amend § 418.102(b) by adding the physician member of the hospice interdisciplinary group, as defined in § 418.56(a)(1)(i), as an individual who may provide the initial certification of terminal illness. We also proposed to amend the medical director CoP in § 418.102(c) to include the medical director, or physician designee, as defined at § 418.3, if the medical director is not available, or physician member of the IDG among the specified physicians who may review the clinical information as part of the recertification of the terminal illness.

We refer readers to section III.B.2 of this final rule for comments and responses received on the proposed payment regulation changes regarding the certification of the terminal illness and admission to hospice care under §§ 418.22 and 418.25, which are also intended to align the medical director CoP and payment regulations.

In this section, we discuss the public comments received on the alignment of language in the existing requirements for hospices regarding the medical director, physician designee, and physician member of the IDG.

We received a total of 27 comments from individuals, health care professionals, and national associations that expressed general support and appreciation for the proposed alignment of language used in the CoPs with the language in the corresponding payment policy. Commenters highlighted how the clarification would reduce variability and confusion related to who provides certification of terminal illness. Additionally, commenters noted that the clarification supports hospice providers and audit contractors and ensures continued care for patients. The following is a summary of the comments we received, our responses, and the policies we are finalizing.

Comment: Multiple commenters expressed support and appreciation for our proposal to align the CoPs at § 418.102 with the payment policy language at §§ 418.22(c) and 418.25, stating that these changes would allow for greater clarity and consistency between key components of the hospice requirements. Commenters also stated the misalignment between the CoPs and the payment requirements has caused some confusion for hospice providers, accrediting bodies, and surveyors and that the proposed conforming changes to the medical director CoP and the payment requirements would result in more clarity and consistency for hospices.

Response: We appreciate the supportive feedback from commenters regarding the alignment of language in the CoPs with language in payment policy.

Comment: Several commenters expressed support for the proposed alignment of the CoPs with the payment policy and recommended further language alignment in the standards for the Medical Director in the hospice CoPs at § 418.102. Specifically, they recommended that we replace the terms "physician designated by" with "physician designee" in the CoP at § 418.102, which states, "When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director." Commenters noted that this would align with the existing terminology used throughout the requirements.

Response: We appreciate the commenters' support and recommendation to further modify the introductory language in the medical director CoP at § 418.102. We agree with the commenters' recommendation to align this first paragraph of the medical director CoP by replacing "physician designated by" with "physician designee" to align the terminology used through the requirements.

Final Decision: After consideration of public comments on this provision, we are finalizing the requirements at § 418.102(b) and § 418.102(c) as proposed. In addition, we are modifying § 418.102 by removing the phrase "physician designated by" and replacing it with "physician designee as defined at § 418.3". The definition of "physician designee" at § 418.3 is defined as, "…a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available." We are finalizing revisions to the medical director standard to state, "The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice. When the medical director is not available, a physician designee as defined at § 418.3, assumes the same responsibilities and obligations as the medical director." Lastly, we are revising the standards for initial certification of terminal illness and recertification of terminal illness at § 418.102(b) and § 418.102(c), respectively, to provide in a parenthetical that physician designee, as defined at

§ 418.3, can conduct the review of clinical information and certification or recertification if the medical director is unavailable.

We believe this modification will provide consistency and alignment in the payment and CoP requirements. These changes align the payment requirements and the health and safety requirements such that there will be consistency across the requirements for hospices, resulting in improved compliance and clearer enforcement activities.

2. Certification of Terminal Illness and Admission to Hospice Care

The Medicare hospice benefit provides coverage for a comprehensive set of services described in section 1861(dd)(1) of the Act for individuals who are deemed "terminally ill" based on a medical prognosis that the individual's life expectancy is 6 months or less, as described in section 1861(dd)(3)(A) of the Act.

As such, section 1814(a)(7)(A) of the Act requires the individual's attending physician (if the patient designates an attending physician) and hospice medical director or physician member of the IDG to certify in writing at the beginning of the first 90-day period of hospice care that the individual is "terminally ill" based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. In a subsequent 90- or 60-day period of hospice care, only the hospice medical director or the physician member of the IDG is required to recertify at the beginning of the period that the patient is terminally ill based on such clinical judgment.

The CoPs at § 418.102 state that "when the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director." The term "physician designee" was utilized in the 1983 hospice final rule (48 FR 56029) that implemented the Medicare hospice benefit when describing who can establish and review the hospice plan of care and was later defined and finalized in the FY 2008 hospice final rule (73 FR 32093) in response to comments requesting CMS clarify this individual's role. Section 418.3 defines "physician designee" to mean a doctor of medicine or

osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available. Currently, the requirements at § 418.22(c), Sources of Certification, state that for the initial 90-day period, the hospice must obtain written certification statements from the medical director of the hospice or the physician member of the IDG and the individual's attending physician if the individual has an attending physician. For subsequent periods, only the "medical director of the hospice or the physician member of the interdisciplinary group" must certify terminal illness. Similarly, the requirements at § 418.22(b), Content of Certification, only include the "the physician's or medical director's" when referencing the clinical judgment on which the certification must be based. Additionally, § 418.25, Admission to Hospice Care, only refers to the recommendation of the hospice medical director (in consultation with the patient's attending physician (if any)) when determining admission to hospice and when reaching a decision to certify that the patient is terminally ill. We note that in the preamble of the proposed rule, we inadvertently referred to paragraph (b) of § 418.22 as the paragraph we proposed to amend. However, the proposed amendment to the text of the regulation was to paragraph (c) of § 418.22. We refer in the preamble to this final rule to the correct paragraph of § 418.22, which is paragraph (c), not paragraph (b).

In order to align §§ 418.22(c) and 418.25 with the CoPs at § 418.102, we proposed to add "physician designee (as defined in § 418.3)" to clarify that when the medical director is not available, a physician designated by the hospice, who is assuming the same responsibilities and obligations as the medical director, may certify terminal illness and determine admission to hospice care. We clarified that this does not connote a change in policy; rather, we believe aligning the language at §§ 418.22(c) and 418.25 with the CoPs at § 418.102 allows for greater clarity and consistency between key components of hospice regulations and policies.

We received 29 comments on these proposed clarifying hospice regulation text changes. A summary of the comments and our responses to those comments are as follows:

Comment: All commenters supported the clarifying regulation text changes and applauded CMS for the clarification and consistency between key components of the hospice regulations. Commenters stated that the clarification will help simplify language, reduce confusion among stakeholders (that is, hospice providers, CMS audit contractors, and Medicare Administrative Contractors (MACs)), and protect hospices against inappropriate citations.

Response: We thank commenters for their support.

Comment: Several commenters requested "physician member of the interdisciplinary group" be added to § 418.25 to further reduce confusion and provide clarity regarding the hospice admission process. Additionally, one commenter requested that nurse practitioners (NPs) and physician assistants (PAs) be allowed to certify a beneficiary as terminally ill and be included on initial hospice certifications.

Response: We thank commenters for their recommendations; however, adding "physician member of the interdisciplinary group" to § 418.25 would be a substantive policy change and the proposals included in the proposed rule were intended only to clarify existing policy. Additionally, allowing NPs and PAs to certify a beneficiary as terminally ill is not permitted under the statute.

Final Decision: We are finalizing the regulation text revisions to add "physician designee (as defined in § 418.3)" at §§ 418.22(c) and 418.25 as proposed.

3. Election of Hospice Care

A distinctive characteristic of the Medicare hospice benefit is that it requires a patient (or their representative) to intentionally choose hospice care by electing the benefit. As part of the election required by § 418.24, a beneficiary (or their representative) must file an "election statement" with the hospice, which must include an acknowledgement that they fully understand the palliative, rather than curative, nature of hospice care as it relates to the individual's terminal illness and related conditions, as well as other requirements as set out at § 418.24(b). Additionally, as set out at § 418.24(f), when electing the hospice benefit, an individual waives all

rights to Medicare payment for any care for the terminal illness and related conditions except for services provided by the designated hospice, another hospice under arrangement with the designated hospice, and the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. Because of this waiver, this means that the designated hospice is the only provider to which Medicare payment can be made for services related to the terminal illness and related conditions for the patient; providers other than the designated hospice, a hospice under arrangement with the designated hospice, or the individual's attending physician cannot receive payment for services to a hospice beneficiary unless those services are unrelated to the terminal illness and related conditions when a patient is under a hospice election.

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452, 50478), we finalized a requirement that a Notice of Election (NOE) must be filed with the hospice MAC within five calendar days after the effective date of hospice election. If the NOE is filed beyond this timeframe, 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 50478). Also, because non-hospice providers may be unaware of a hospice election, late filing of the NOE leaves Medicare vulnerable to paying non-hospice claims related to the terminal illness and related conditions when these services are furnished by these non-hospice providers. Moreover, beneficiaries may potentially be liable for any associated cost-sharing they would not have incurred if these services were furnished by the hospice provider.

When discussing hospice election, stakeholders (such as Medicare contractors, medical reviewers, and hospices) often conflate the terms "election statement" and "NOE." Further, we have received recent inquiries requesting clarification on timeframe requirements for both the election statement and the NOE that indicate confusion between such documents. Upon review of this regulation, we believe the organization at § 418.24 does not make it clear that these are two separate and distinct documents intended for separate purposes under the benefit. We

proposed to reorganize the language in this section to clearly denote the differences between the election statement and the NOE. That is, we proposed to title § 418.24(b) as "Election Statement" and would include the title "Notice of Election" at § 418.24(e). We stated that by clearly titling this section, the requirements for the election statement and the notice of election would be distinguished from one another, mitigating any confusion between the two documents. These changes would align with existing subregulatory guidance. We also noted this reorganization would not be a change in policy, rather it is intended to identify the requirements more clearly for the election statement and the NOE by reorganizing the structure of the regulations. We believe this reorganization is important to ensure that stakeholders fully understand that the election statement is required as acknowledgement of a beneficiary's understanding of the decision to elect hospice and filed with the hospice, whereas the NOE is required for claims processing purposes and filed with the hospice MAC within five calendar days after the effective date of the election statement.

We also noted that the MACs have informed us of ongoing instances of hospices omitting certain elements of the hospice election statement. We reminded readers that a complete election statement containing all required elements as set forth at § 418.24(b) is a condition for payment. Additionally, we emphasized the importance of each element in informing the beneficiary of their coverage when choosing to elect the Medicare hospice benefit. We continued to encourage hospice agencies to utilize the "Model Example of Hospice Election Statement" on the hospice webpage at https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice to limit potential claims denials.

We received 21 comments on the proposed clarification of the election statement and the NOE. A summary of the comments and our responses to those comments are as follows:

Comment: All commenters supported the reorganization and clarification of the election statement and the NOE and expressed appreciation that CMS is working to mitigate confusion between the two documents and promoting clarity. Other commenters stated that the changes are

helpful in clarifying key components of the hospice regulations for hospice providers, Administrative Law Judges (ALJs), CMS audit contractors, MACs, and other stakeholders.

Response: We thank commenters for their support.

Comment: We received four comments on the reference to the model election statement and a concern that the MACs are treating the model election statement example as a required form despite CMS instruction that the model election statement is intended to be an example of a form agencies can utilize if desired. Specifically, a few commenters reported receiving "technical denials" from MACs when specific language or organization did not match the election statement example. Lastly, a commenter suggested that CMS conduct an analysis of overturned claim denials to improve audit activity.

Response: We thank the commenters for their feedback. We reiterate that the model election statement is intended to be an example of a form that hospices may utilize and that hospice agencies are not required to use this exact example. We appreciate the suggestion to analyze overturned claim denials in order to improve future audit activity.

Comment: One commenter recommended the physician national provider identifier (NPI) number be included on the model hospice election statement.

Response: We thank the commenter for the suggestion. A provider may add additional information, such as an NPI number, to their own election statement; however, we do not want providers to infer the NPI is required under § 418.24(b), and as such, will not add it to the model election statement at this time.

Final Decision: We are finalizing the regulation text revisions to reorganize and clarify the election statement and the NOE requirements at § 418.24 as proposed.

4. Hospice Marriage and Family Therapist Technical Edit

In the final rule that appeared in the November 16, 2023 **Federal Register** on (88 FR 78818) titled "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare

Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program" there is one technical error noted in the hospice personnel requirements at § 418.114(b)(9) that is identified and corrected in this final rule.

Throughout the final rule (88 FR 78818) we correctly used the term "marriage and family therapist." However, on page 79539 under § 418.114(b)(9) of the final rule, we inadvertently finalized regulation text that uses the term "marriage and family counselor" when the correct term is "marriage and family therapist." Therefore, we are making a technical correction in this final rule by replacing "marriage and family counselor" with "marriage and family therapist" at § 418.114(b)(9).

C. Request for Information (RFI) on Payment Mechanism for High Intensity Palliative Care Services

We define hospice care as a set of comprehensive services described in section 1861(dd)(1) of the Act, identified and coordinated by an IDG to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care (§ 418.3). Hospice care changes the focus of a patient's illness to comfort care (palliative care) for pain relief and symptom management from a curative type of care. Under the hospice benefit, palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. CMS continually works to ensure access to quality hospice care for all eligible Medicare beneficiaries by establishing, refining, readapting, and reinforcing policies to improve the value of care at the end of life for these beneficiaries. That is, we seek to strengthen the notion that in order to provide the highest level of care for hospice beneficiaries, we must

provide ongoing focus on those services that are consistent with CMS' definitions of hospice and palliative care and eliminate any barriers to accessing hospice care.

Adequate care under the hospice benefit has consistently been associated with symptom reduction, less intensive care, decreased hospitalizations, improved outcomes from caregivers, lower overall costs, and higher alignment with patient preferences and family satisfaction.[5] Although hospice use has grown considerably since the inception of the Medicare hospice benefit in 1983, there are still barriers that terminally ill and hospice benefit eligible beneficiaries may face when accessing hospice care. Specifically, the national trends[6] that examine hospice enrollment and service utilization for those beneficiary populations with complex palliative needs and potentially high-cost medical care needs reveal that there may be an underuse of the hospice benefit, despite the demonstrated potential to both improve quality of care and lower costs.[7]

There is a subset of hospice eligible beneficiaries that would likely benefit from receiving palliative, rather than curative, chemotherapy, radiation, blood transfusions, and dialysis. Anecdotally, we have heard from beneficiaries and families their understanding that upon election of the hospice benefit, certain therapies such as dialysis, chemotherapy, radiation, and blood transfusions are not available to them, even if such therapies would provide palliation for their symptoms. Generally, these patients report that they have been told by hospices that Medicare does not allow for the provision of these types of treatments upon hospice election. While these types of treatments are not intended to cure the patient's terminal illness, some practitioners, with input from the hospice IDG, may determine that, for some patients, these

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[5] Obermeyer Z, Makar M, Abujaber S, Dominici F, Block S, Cutler DM. Association Between the Medicare Hospice Benefit and Health Care Utilization and Costs for Patients With Poor-Prognosis Cancer. JAMA. 2014;312(18):1888–1896. doi:10.1001/jama.2014.14950.

[6] Wachterman MW, Hailpern SM, Keating NL, Kurella Tamura M, O'Hare AM. Association Between Hospice Length of Stay, Health Care Utilization, and Medicare Costs at the End of Life Among Patients Who Received Maintenance Hemodialysis. JAMA Intern Med. 2018 Jun 1;178(6):792–799. doi: 10.1001/jamainternmed.2018.0256. PMID: 29710217; PMCID: PMC5988968.

[7] Meier DE. Increased access to palliative care and hospice services: opportunities to improve value in health care. Milbank Q. 2011Sep;89(3):343–80. doi: 10.1111/j.1468–0009.2011.00632.x. PMID: 21933272; PMCID:PMC3214714.

adjuvant treatment modalities would be beneficial for symptom control. In such instances, these palliative treatments would be covered under the hospice benefit because they are not intended to be curative. In the FY 2024 Hospice final rule (88 FR 51168), we noted in response to our RFI on hospice utilization; non-hospice spending; ownership transparency; and hospice election decision-making, that commenters stated providing complex palliative treatments and higher intensity levels of hospice care may pose financial risks to hospices when enrolling such patients. Commenters stated that the current bundled per diem payment is not reflective of the increased expenses associated with higher-cost and certain patient subgroups. As we continue to focus on improved access and value within the hospice benefit, we solicited additional information on the potential implementation of a payment mechanism to account for the increased costs of providing more intensive palliative treatments.

We received approximately 60 comments on our RFI on high-cost palliative services. Most of the comments we received included both general recommendations as well as specific comments in response to the questions asked in the proposed rule. Therefore, we summarize general comments, followed by specific comments we received in response to each question presented in the proposed rule.

Comment: A few commenters suggested that, to minimize the complexity of the topic and prior to consideration of RFI responses, CMS should first avoid using "comfort care" interchangeably with "palliative care", clearly distinguish between "hospice care" and "palliative care", and remove the term "palliative" altogether and replace it with "high-cost therapies". Many commenters stated there is an underutilization of the hospice benefit, in part due to the availability of high-cost, intensive services outside of the hospice benefit (that is services covered under another Medicare benefit, such as ESRD). For example, several commenters stated that patients often choose not to elect hospice, or they elect later in the trajectory of their illness, as they would need to give up the option for many of the palliative but higher cost treatments. This often results in patients electing hospice services in the final days or weeks of

their lives when the patient and their families do not receive the full benefit of hospice. Several anecdotal stories were provided in support of continuing these high-cost services, particularly home blood transfusions, and often these were provided to align with patient goals at end of life. A few commenters stated the issue is not a lack of access to these services, but rather hospices' decisions that the costs of these services are prohibitive. A few commenters expressed concern about potential fraudulent activity by certain providers if a separate payment mechanism was established and suggested that CMS should first identify gaps in care and potential fraud, waste, and abuse. The commenters recommended incentivizing advance care planning, as well as monitoring and enforcing appropriate provisions of the hospice benefit. Another commenter stated the financial impact is not the only concern for electing hospice; they stated that there can be a concern related to a patient's prognosis and understanding palliative treatment versus a reluctance to forgo a plan to continue curative treatment. The commenter recommended CMS consider the roles of specialists (oncologists, hematologists, etc.) when determining the impact of this potential policy on the hospice philosophy of reducing patients' suffering as well as the requirement to determine a life expectancy of six-months or less. Some commenters requested that CMS consider additional data mining to determine whether high intensity, high-cost palliative treatments are offered more frequently during the course of a hospice stay versus upon admission when conflicting goals of the medical providers are more obvious. Lastly, a commenter recommended better electronic medical record (EMR) coordination and interoperability between the hospice teams and specialists to ensure all potential treatments are communicated. Multiple commenters, including several national organizations, stated concern that under the current statutory budget neutrality requirement, the introduction of any new payment would have to be offset by reductions to existing payments. Commenters stated they do not believe this is tenable given hospices' financial pressures and the challenges they already experience paying for high-intensity palliative services under the current reimbursement rates. Likewise, a few commenters stated that smaller and non-profit hospices disproportionately tend

to care for the sickest patients who often require these types of high-intensity services, and the costs associated with providing these higher-intensity services are too often prohibitive, particularly for these small hospices and non-profit hospices. Commenters expressed concern that any changes implemented under CMS' current statutory authority would not sufficiently address this issue. These commenters recommended CMS work with industry stakeholders to pursue legislative authority from Congress to create a payment policy to ensure that hospice patients have adequate access to high intensity palliative care services. In addition, commenters recommended CMS convene a Technical Expert Panel (TEP) in conjunction with robust data collection to be able to advance those discussions. For robust data collection, several commenters recommended gathering comprehensive data on historic and current beneficiary utilization of high-cost palliative interventions for hospice and hospice-eligible patients, conducting an analysis of any specific barriers impacting access to these services throughout the care continuum, and developing rules, protocols, and sustainable payment avenues for these kinds of treatments to improve access to hospice for traditionally underserved patients and families that come from diverse racial and ethnic backgrounds.

MedPAC reported it plans to conduct research regarding access to hospice and end-of-life care for beneficiaries with End Stage Renal Disease (ESRD), interviewing clinicians; hospice providers; and ESRD facilities, including programs that provide palliative kidney care, and other groups.

A few commenters recommended providing further education and clarity to providers and new hospice enrollees upfront to promote a better understanding of the coverage policy regarding the appropriateness of the use of high intensity palliative care services in conjunction with traditional hospice services. These commenters also recommended CMS issue guidance, rules, or incentives that make it easier for hospices to secure contracts with the upstream providers of these services. Several commenters recommended implementing measures to reduce administrative burden to hospices for these high-cost services.

We received a comment that greater utilization of physician assistants (PAs) has the potential to reduce care barriers and move toward ameliorating the problem of eligible beneficiaries not sufficiently accessing hospice services, including high-cost palliative services. The commenter recommended modifying the hospice regulations and the Medicare Benefit Policy Manual to authorize PAs employed by the hospice to serve in the role of a patient's attending physician if an attending physician was not previously selected by the patient.

Below are the questions we posed in RFI in the proposed rule, along with the comment summaries.

What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?

Comment: Several commenters strongly supported a more robust payment for high intensity palliative care services to help cover the costs. Specifically, we received multiple comments stating that if all hospices are expected to regularly provide complex palliative treatments and higher intensity levels of hospice care, additional payment or a higher daily per diem rate must be provided for patients receiving these complex, high-cost treatments. Commenters stated higher payment rates, add-on payments, or an outlier payment would allow hospice agencies to provide the additional treatments and staff to support higher intensity care without having significant financial burdens. Specifically, commenters suggested additional payments for staff training and resource support to sufficiently ensure skills to deliver high-quality, complex care and staff retention to support quality patient outcomes and cost-effective care delivery.

Commenters stated these extra payments should not only include the cost of the service or item itself, but also costs associated with the care management and coordination activities such as monitoring, mapping, office visits, repeat imaging, and transportation. Commenters recommended various modifiers or "payment tiers" to reflect the intensity of services or resource utilization, and suggested CMS analyze the cost of care for various services to determine

individual payment tiers, as well as implementing a "cap" for these higher intensity service payments.

Other commenters opposed additional payment under the hospice benefit and multiple commenters recommended some version of a carve out or concurrent care payments. We received several comments recommending different payment models including adopting the Medicare Care Choices Model (MCCM) or a modified version of the MCCM and reviving and expanding the Medicare Coordinated Care Demonstration (MCCD). Many commenters stated that CMS should not attempt to cover these high-cost services within the existing hospice benefit payment structure, rather specialty providers should be able to bill Medicare Part B directly while the patient remains under a hospice plan of care. These commenters recommended CMS permit conditioned access to these treatments for beneficiaries concurrently enrolled in hospice and develop new policy and payment guidelines for the specialty practitioners. They suggested these practitioners could use modifiers and advised limiting the number of treatments while patients are under a hospice election. Some commenters recommended that the concurrent care payment for high-cost palliative treatments only be available during the first benefit period.

A few commenters recommended that in addition to covering high-cost treatments and their related medications, it would also be beneficial for Medicare to cover high-cost medications unrelated to higher intensity services (for example, novel oral anticoagulants, certain inhalers, antibiotics, other medications typically used for curative purposes) when provided with palliative intent.

What specific financial risks or costs are of particular concern to hospices that would prevent the provision of higher-cost palliative treatments when appropriate for some beneficiaries? Are there individual cost barriers which may prevent a hospice from providing higher-cost palliative care services? For example, is there a cost barrier related to obtaining the appropriate equipment (for example, dialysis machine)? Or is there a cost barrier related to the treatment itself (for example, obtaining the necessary drugs or access to specialized staff)?

Comment: Almost all commenters provided specific financial risks and cost barriers to providing higher-cost palliative care services. Commenters stated that across all diagnoses and situations there is a wide variance of incremental costs involved in higher intensive care. Commenters described barriers related to both direct and ancillary costs. The most cited expenses included the treatment itself, staffing, equipment, transportation logistics, contracting, facility usage, and administrative burden.

Many commenters stated these palliative treatments require the use of high-cost drugs, which represent a significant proportion of the cost. Commenters noted even medications covered by Medicare Part D prior to hospice election continue to prove challenging for hospices to manage. Commenters stated that these high-cost palliative treatments can also require additional medications to address burdensome side effects and symptoms of the interventions themselves. Several commenters recommended developing a national formulary with negotiated rates that hospices could use to procure medications or seek to leverage Veterans Affairs pharmacy contracts. Alternatively, one commenter noted that while the equipment required for these services will still be needed, some of the drugs and related supplies (for bundled and separately payable drugs) and labs could potentially be discontinued or reduced, as they may not support the goals of comfort at the end of life.

Commenters also stated many of these treatments require specialized staff, such as oncologists, nephrologists, and trained nurses who have the expertise to administer complex treatments like chemotherapy and dialysis. Commenters noted the salaries and benefits for these specialized professionals are higher than for general hospice staff, adding to the financial burden on hospices. In addition, existing hospice staff may need additional training and certifications to understand and/or help administer and educate patients and families on these interventions and their side effects. Commenters stated the costs associated with staff training can include course fees, travel, and time away from regular duties which can present a significant barrier. Commenters also stated these high intensity patients also typically require more frequent

medication adjustments requiring more frequent provider and nursing visits, which increases the financial burden. A commenter noted for many of these services, there is also an increased complexity for the caregiver at home, therefore there can be a greater need for respite and GIP care.

Several commenters stated that the cost of specialized equipment can vary depending on the treatment provided. Although one commenter said it is unlikely that a hospice would obtain the necessary equipment, such as a dialysis machine, as it is available in most communities, many commenters raised issues securing contracts with specialty providers and hospitals or other facilities where these treatments are administered. Commenters also stated the contracting and payment processes for these services would be an uncharted and potentially confusing process for the hospices and specialty providers alike. In addition, commenters stated hospice providers are unable to negotiate contracts at Medicare allowable rates for these related services, and therefore providers of these high-cost palliative treatments may be reluctant to reduce costs for hospices compared to other existing reimbursement rates. A few commenters noted that even if a contract is in place, there may be a lack of access to beds and treatments when needed.

Commenters also stated a potential burden with care management, such as coordination with the facilities where these treatments are delivered and with the providers who deliver them. Commenters reported that hospices can dedicate significant resources when arranging for high-intensity services including labs, imaging, and transportation for patients and family to a location where these high-cost treatments are administered. One commenter also stated patients and their specialty providers, not the hospice provider, decide where to receive treatment, and that beneficiaries may choose to continue receiving dialysis from their current provider, rather than the hospice-contracted provider.

A commenter also reported that regulatory burdens related to compliance requirements governing the provision of complex palliative treatments may add administrative burden and costs to the agency. Overall, commenters stated the complexity and variability of these costs,

coupled with uncertainties in reimbursement rates for such services, pose significant barriers for hospices to offer them routinely.

Should there be any parameters around when palliative treatments should qualify for a different type of payment? For example, we are interested in understanding from hospices who do provide these types of palliative treatments whether the patient is generally in a higher level of care (CHC, GIP) when the decision is made to furnish a higher-cost palliative treatment? Should an additional payment only be applicable when the patient is in RHC?

Comment: Most commenters stated CMS should not limit higher reimbursement for complex treatments to certain types of patients. Commenters stated that patients at any level of care could benefit from a high-cost palliative service and that such service should not only be provided to patients in a higher level of care.

Several commenters stated that the use of these services does not necessarily correlate to a need for a higher intensity level of hospice care and therefore, beneficiaries do frequently remain at an RHC level. For example, a commenter stated that beneficiaries with uncontrolled symptoms and at the CHC or GIP level of care are unlikely to be candidates for receiving these high intensity services as these services are intended for long-term symptom management rather than acute symptom management. However, several commenters stated there are times when a patient might be eligible for a higher level of care for reasons unrelated to the administration of the high intensity palliative services, but that high intensity service might still be appropriate.

Commenters also reported that symptom burden can also result in the need for GIP or CHC and providing a higher intensity palliative treatment during RHC may reduce or eliminate the need for this higher level of care.

We received a few comments in support of establishing parameters around these high-cost palliative services. These commenters recommended that payment for higher cost palliative treatments should be subject only to the determination based on the ability to improve the person's quality of life. That is, these treatments should only be utilized by a hospice beneficiary

expressly for palliative purposes as evidenced by current clinical guidelines for the treatment's utilization as palliative care. Another commenter stated guidelines for additional payments should be based upon identified symptom burden that would reasonably be expected to be relieved or managed by the palliative intervention with specified outcomes.

Another commenter stated that moving to a higher level of care (for example, GIP, CHC) could trigger higher cost palliative treatments or that these patients may need a higher level of monitoring and would therefore be expected to be in GIP or CHC while receiving these treatments.

Under the hospice benefit, palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). In addition to this definition of palliative care, should CMS consider defining palliative services, specifically regarding high-cost treatments? Note, CMS is not seeking a change to the definition of palliative care, but rather should CMS consider defining palliative services with regard to high-cost treatments?

Comment: A few commenters stated it can be easy to misconstrue the use of high-cost services, as the intent, dose, duration, or stage of the illness can dictate whether these services are palliative or curative. Additionally, commenters recommended first considering how palliative care fits within the current hospice benefit especially if palliative care is life prolonging. Another commenter recommended any palliative definitions should align with the Center to Advance Palliative Care (CPAC) definitions related to palliation.

We received multiple comments in support of defining palliative services, particularly for additional reimbursement. Commenters in support of a definition of palliative services stated it could help provide clarity, standardization, and understanding about the types of services that would be included under this potential additional payment category which could help promote equity in patient care. Commenters stated a definition of palliative services should characterize these services as resource intensive services that are independent of curative treatments. A few

commenters, while in support of a definition, also cautioned that any definition should be broad enough so as not to inadvertently exclude certain services. For example, commenters stated the definition should not specify individual drugs, durable medical equipment (DME), or other therapies, to allow for separate billing for these items. Another commenter stated a definition of palliative services should be specific to services offered under the Medicare hospice benefit, to eliminate potential confusion that this would be a separate palliative care benefit. Lastly, some commenters in support of defining palliative services stated establishing specific criteria can help prevent overuse or misuse of expensive treatment, as well as allow hospices to better plan financially and ensure they are adequately compensated for providing these complex and expensive services.

We also received multiple comments in opposition of defining palliative services. These commenters stated defining services that could be disease-modifying as palliative is a dynamic area and instead treatments should be determined on an individual patient basis rather than explicitly defining palliative services. Commenters stated a flexible approach is needed, as patient and family goals and needs are highly specific and medical advances in the future could result in as-yet unidentified treatments that could be considered "palliative services." A few commenters stated defining palliative services would be a substantial undertaking that would require broad stakeholder engagement, as narrowing the definition of palliative care based on certain services would likely lead to additional confusion and administrative burden. As such, any definition of "palliative services" as separate from the definition of palliative care should be focused on facilitating understanding of payment of these services.

Should there be documentation that all other palliative measures have been exhausted prior to billing for a payment for a higher-cost treatment? If so, would that continue to be a barrier for hospices?

Comment: Commenters stated the focus should be on the goals and quality of life for beneficiaries. They stated that physicians' clinical judgment should be the basis to determine if

such treatment is necessary and beneficial to the patient. Commenters raised concerns that requiring all other palliative measures be exhausted prior to billing for a higher-cost treatment is nebulous and could be a barrier to patient care. Multiple commenters stated, while the rationale for billing for a higher-cost treatment should be documented in the record, they oppose additional requirements to document that all other palliative measures have been exhausted prior to billing for a higher-cost service. They stated this could lead to inefficiencies, administrative burden, unnecessary services, delays in hospice admissions leading to shorter lengths of hospice stays, and delays in the relief of symptoms. Commenters also stated that time spent trying other, potentially lower cost but ineffective interventions before utilizing the higher cost treatment will raise total costs for these patients and extend the time they are not receiving proper care for their condition(s). Commenters also stated as treatment decisions are often made urgently, CMS should limit the barriers to the use of complex treatments. And finally, commenters stated this could undermine the clinical judgment of the hospice IDG and upstream providers and lead to fear of retrospective audits questioning the clinical appropriateness of providing one treatment instead of another. These commenters stated that determining when all other measures have been exhausted may be clinically subjective and challenging, leading to variations in interpretation and exacerbating delays in treatment or claims denials.

Other commenters stated that the use of complex treatments is individualized and should be used only if all other treatments have been tried. Commenters recommended that documentation should include the symptoms being addressed, the treatments that have been tried unsuccessfully, and the plan for using a particular complex treatment. Some commenters stated that requiring documentation that all other palliative measures have been exhausted prior to billing ensures high-cost treatments are used as a last resort and maintains cost-effectiveness and appropriate resource allocation; however, as this could be a huge barrier to hospice providers, they suggested that covering these treatments outside of the hospice benefit may help eliminate this burden.

Should there be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment that would exceed the per-diem rate?

Comment: A few commenters stated that making blanket inclusions of therapies in all situations would not align with the hospice philosophy and recommended separate payments for different treatments. Other commenters noted the costs of these treatments vary greatly, and separate payments would be necessary to adequately account for this variation. Commenters stated that separate payments would ensure that hospices have adequate financial resources to provide a range of higher-cost treatments as needed. They stated each treatment should be reimbursed at a predetermined rate, reflecting its value and cost-effectiveness and separate from the standard per diem payment for hospice care. Multiple commenters recommended using Medicare allowable rates and existing CPT or HCPCS codes sets. Other recommendations included individual billing modifiers that could be used when these treatments are furnished to a hospice patient for palliative purposes. Commenters also noted that a single rate to cover all high-cost treatments would inevitably pay too much for some and not enough for others.

We received several comments in support of a single per diem rate for all high-cost treatments. Commenters stated that one standard payment for any higher-cost treatment would be in alignment with the structure of the per diem rate provided by hospice for standard care and reduce confusion. Other commenters noted that having separate payments for different types of higher-cost palliative treatments could lead to a particular therapy being inadvertently left out of the higher cost structure and managing separate payments could increase administrative complexity to the claim-submission process.

A few commenters stated either option would work as long as it alleviates the concerns of the financial impact of these high-cost treatments and other commenters recommended simply increasing reimbursement overall to encompass the costs of high-intensity treatments. A few commenters recommended starting with a single payment for a period of time while CMS engages in a robust cost analysis to develop the most appropriate payment mechanism. And

finally, many commenters stated CMS should not have separate payments nor a single payment, and instead cover these treatments separately from the existing hospice benefit. Commenters again recommended concurrent care and suggested carving out these palliative treatments under Medicare Part B.

Response: We thank the commenters for their insight and thoughtful recommendations. We are incredibly appreciative of the time and effort readers put forth in collaborating with CMS as we explore ways to improve coverage under the Medicare hospice benefit. We will consider all comments and recommendations received on this rule and will continue to welcome thoughts regarding these issues through our hospice policy mailbox at hospicepolicy@cms.hhs.gov. We also remind readers they can report suspected fraud, waste, or abuse to CMS. Further information on reporting fraud can be found in The Medicare & You handbook at page 105 and at https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity/reporting-fraud. Readers can also report suspected fraud, waste, and abuse to the Office of Inspector General at https://oig.hhs.gov/fraud/report-fraud/.

D. Proposals to the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) specifies reporting requirements for the Hospice Item Set (HIS), administrative data, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality reporting program for hospices, and requires, beginning with FY 2014, that the Secretary reduce the market basket update by 2 percentage points for those hospices failing to meet quality reporting requirements. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points beginning in FY 2024 for any hospice that does not comply with the quality data submission requirements for that FY. In the FY 2024 Hospice final rule, we codified the application of the

4-percentage point payment reduction for failing to meet hospice quality reporting requirements and set completeness thresholds at § 418.312(j).

Depending on the amount of the annual update for a particular year, a reduction of 4 percentage points beginning in FY 2024 could result in the annual 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. Typically, about 18 percent of Medicare-certified hospices are found non-compliant with the HQRP reporting requirements annually and are subject to the APU payment reduction for a given FY.

In the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48234, 48257 through 48262), and in compliance with section 1814(i)(5)(C) of the Act, we finalized a new standardized patient-level data collection vehicle called the Hospice Item Set (HIS). We also finalized the specific collection of data items that support eight consensus-based entity (CBE)-endorsed measures for hospice.

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452), we finalized national implementation of the CAHPS® Hospice Survey, 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 the FY 2014 and FY 2015 Hospice Wage Index and Payment Update final rules (78 FR 48261 and 79 FR 50452, respectively). National implementation commenced January 1, 2015. We adopted eight CAHPS® survey-based measures for the CY 2018 data collection period and for subsequent years. These eight measures are publicly reported on the Care Compare website.

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142, 47186 through 47188), we finalized the policy for retention of HQRP measures adopted for previous

payment determinations and seven factors for removal. In that same final rule, we discussed how we would provide public notice through rulemaking of measures under consideration for removal, suspension, or replacement. We also stated that if we had reason to believe continued collection of a measure raised potential safety concerns, we would take immediate action to remove the measure from the HQRP and not wait for the annual rulemaking cycle. The measures would be promptly removed and we would immediately notify hospices and the public of such a decision through the usual HQRP communication channels, including but not limited to listening sessions, email notifications, Open Door Forums, and Web postings. In such instances, the removal of a measure will be formally announced in the next annual rulemaking cycle.

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.

In the FY 2017 Hospice Wage Index and Payment Rate Update final rule, we finalized the "Hospice Visits When Death is Imminent" measure pair (HVWDII, Measure 1 and Measure 2), effective April 1, 2017. We refer the public to the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52144, 52163 through 52169) for a detailed discussion.

As stated in the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622, 38635 through 38648), 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. The Meaningful

Measures Initiative is not intended to replace any existing CMS quality reporting programs, but will help such programs identify and select individual measures. The Meaningful Measure Initiative areas are intended to increase measure alignment across our quality programs and other public and private initiatives. Additionally, it will point to high priority areas where there may be gaps in available quality measures while helping to guide our efforts to develop and implement quality measures to fill those gaps. 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 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), we finalized two new measures using claims data: (1) Hospice Visits in the Last Days of Life (HVLDL); and (2) Hospice Care Index (HCI). We also removed the Hospice Visits when Death is Imminent (HVWDII) measure, as it was replaced by HVLDL. We also finalized a policy that claims-based measures would use 8 quarters of data to publicly report on more hospices.

In addition, we removed the seven Hospice Item Set (HIS) Process Measures from the program as individual measures, and ceased their public reporting because, in our view, the HIS Comprehensive Assessment Measure is sufficient for measuring care at admission without the seven individual process measures. In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42553), we finalized § 418.312(b)(2), which requires hospices to provide administrative data, including claims-based measures, as part of the HQRP requirements for § 418.306(b). In that same final rule, we provided CAHPS Hospice Survey updates.

As finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), public data reflecting hospices' reporting of the two new claims-based quality measures (QMs), the "Hospice Visits in Last Days of Life" (HVLDL) and the "Hospice Care Index" (HCI) measures, are available on the Care Compare/Provider Data Catalogue (PDC) webpages as of the August 2022 refresh. In the FY 2023 and FY 2024 Hospice Wage Index final rules, we did not propose any new quality measures. However, we provided updates on

already-adopted measures. Table 13 shows the current quality measures in effect for the FY 2025 HQRP, which were finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule and have been carried over in each subsequent year.

TABLE: 13 Quality Measures in Effect for the Hospice Quality Reporting Program

Hospice Quality Reporting Program
Hospice Item Set
Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen 2. Pain Screening 3. Pain Assessment 4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 7. Beliefs/Values Addressed (if desired by the patient)
Administrative Data, including Claims-based Measures
Hospice Visits in Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1)–Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2)–Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient 7. Rating of this hospice 8. Willing to recommend this hospice

2. Implementation of Two Process Quality Measures Based on Proposed HOPE Data Collection

Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality reporting program for hospices, develop and implement quality measures, and publicly report quality measures. In this final rule, we are finalizing the addition of two process measures no

sooner than FY 2028 to the HQRP calculated from data collected from HOPE: *Timely Follow-Up for Pain Impact* and *Timely Follow-Up for Non-Pain Symptom Impact*. We will use the data collected from HOPE (see section III.D.3 on the proposal to implement HOPE and associated PRA), which a nurse would assess at multiple time points during a hospice stay to collect data related to patients' symptoms during those assessments. These two measures will determine whether a follow-up visit occurs within two (2) days of an initial assessment of moderate or severe symptom impact.

Symptom alleviation is an important aspect of hospice care, including both pain management and non-pain symptom management. CMS has heard this feedback consistently from both clinicians and caregivers, including the Technical Expert Panel (TEP) which CMS convened from 2019 through 2023. At present, HQRP only has a component of a measure indicating whether the pain symptom was assessed, as a part of the comprehensive assessment at admission measure. This measure alone does not adequately measure whether hospices are alleviating hospice patients' symptoms throughout their hospice stay.

CMS considers symptom management an important domain to address further via the HQRP program. Therefore, we will implement these new concepts on timely follow-up of symptoms with the support and input of hospice experts. For cases where a patient is assessed as having high (that is, more severe) symptom impact, practitioners suggest that good care processes include trying to follow-up with the patient and having in-person visits within two (2) days to ensure treatment has helped alleviate and/or manage those symptoms. Therefore, we are finalizing two process measures derived from HOPE data – *Timely Follow-Up for Pain Impact* and *Timely Follow-Up for Non-Pain Symptom Impact* – will capture these care processes.

Our paramount concern is the successful development of an HQRP that promotes the delivery of high-quality healthcare services. We seek to adopt measures for the HQRP that promote efficient, safer, and patient-centered care. Our measure selection activities for the HQRP take into consideration input we receive from the CBE, as part of a pre-rulemaking

process that we have established and are required to follow under section 1890A of the Act. The CBE convenes interested parties from multiple groups to provide CMS with recommendations on the Measures Under Consideration (MUC) list. This input informs how CMS selects certain categories of quality and efficiency measures as required by section 1890A(a)(3) of the Act. By February 1st of each year, the CBE must provide that input to CMS. For more details about the pre-rulemaking process, please visit the Partnership for Quality Measurement website at https://p4qm.org/PRMR.

We also consider national priorities, such as those established by the Partnership for Quality Measurement, the HHS Strategic Plan, and the National Strategy for Quality Improvement in Healthcare located at https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/quality03212011a. To the extent possible, we have sought to adopt measures that have been endorsed by the national CBE, recommended by multiple organizations of interested parties, and developed with the input of providers, payers, and other relevant stakeholders.

a. Measure Importance

The FY 2019 Hospice Wage Index 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. The Initiative helps guide our efforts to develop and implement quality measures to fill those gaps and develop those concepts towards quality measures that meet the 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 hospice care services throughout the dying

process, fit well with the hospice business model, and meet the objectives of the Meaningful Measures Initiative.

To that end, the *Timely Follow-Up for Pain Impact* and *Timely Follow-Up for Non-Pain Symptom Impact* measures will add value to HQRP by filling an identified informational gap in the current measure set. Specifically, the *Timely Follow-Up for Pain Impact* process measure will determine how many patients assessed with moderate or severe pain impact were reassessed by the hospice within 2-calendar days, and the *Timely Follow-Up for Non-Pain Symptom Impact* process measure will determine how many patients assessed with moderate or severe non-pain impact were reassessed by the hospice within 2-calendar days. Compared to the single existing HQRP measure that includes pain symptom assessment, the two HOPE-based process measures will better reflect hospices' efforts to alleviate patients' symptoms on an ongoing basis.

b. Specifications of the Measures

We are finalizing that both the process measures based on HOPE data will be calculated using assessments collected at admission or the HOPE Update Visit (HUV) timepoints. Pain symptom severity and impact will be determined based on hospice patients' responses to the pain symptom impact data elements within HOPE. Non-pain symptom severity and impact will be determined based on patients' responses to the HOPE data elements related to shortness of breath, anxiety, nausea, vomiting, diarrhea, constipation, and agitation. Additional information regarding these data items and time points can be found in the draft HOPE Guidance Manual of the HOPE webpage at https://www.cms.gov/medicare/quality/hospice/hope and the PRA package that accompanies this Rule can be accessed at https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing. We finalize the proposal that only in-person visits will count for the collection of data for these proposed measures – that is, telehealth calls will not count for a follow-up. We sought comment on whether only in-person visits are appropriate for collection of data for these proposed measures or if other types of visits, such as telehealth, should be included. We are

finalizing the decision that a follow-up visit cannot be the same visit as the initial assessment, but it can occur later in the same day (as a separate visit).

However, we recognize that requiring in-person visits may impact existing staffing shortages faced by many hospice providers. CMS maintains to avoid creating unnecessary burden for hospice providers. Therefore, to minimize the burdensome impact of the in-person staffing requirement and to take advantage of the staff members hospices have, we are finalizing a decision that symptom follow-up visits (SFVs), referred to in the proposed rule as the Symptom Reassessment, may be performed by either RNs or Licensed Practical Nurses (LPNs)/Licensed Vocational Nurses (LVNs).

For both the *Timely Follow-Up for Pain Impact* and *Timely Follow-Up for Non-Pain Symptom Impact* measures, beneficiaries will be included in the denominator if they have a moderate or severe level of pain or non-pain symptom impact, respectively, at their initial assessment. However, certain exclusions will apply to these denominators, such as beneficiaries who die or are discharged alive before the two-day window, if the patient/caregiver refused the follow-up visit, the hospice was unable to contact the patient/caregiver to perform the follow-up, the patient traveled outside the service area, or the patient was in the ER/hospital during the two-day follow-up window. In these situations, a hospice will be unable to conduct a follow-up due to circumstances beyond their control, and therefore these situations will not be included in the measure denominator.

The numerators for these measures will reflect beneficiaries who did receive a timely symptom follow-up. These will include beneficiaries who receive a separate HOPE follow-up within 2-calendar days of the initial assessment (for example, if a pain has moderate or severe symptoms assessed on Sunday, the hospice would be expected to complete the follow-up on or before Tuesday).

c. Measure Reportability, Variability, and Validity

As part of developing these quality measures, CMS and their measure development contractor conducted simulations of measure reportability rates and measure variability. We used the results of the HOPE Beta Test to estimate HOPE data availability for a national population of hospice patients. Detailed information regarding reportability and variability testing is provided in the HOPE Beta Testing Report, available on the HOPE webpage at https://www.cms.gov/medicare/quality/hospice/hope. Additionally, CMS assessed each proposed quality measure face validity with input from TEP members convened in March 2023. Further information about our validity analysis is provided in the 2022-2023 HQRP TEP Report, available in the Downloads section of the HQRP Provider and Stakeholder Engagement page. Our reportability and variability analyses did not present concerns for the proposed HOPE-based process measures, and our validity analysis indicated that the proposed measures have high face validity.

d. Future Plans for Testing HOPE-Based Quality Measures

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

e. Public Engagement and Support

CMS engaged the public in multiple stages of HOPE-based measure development. To support measure development, CMS convened multiple technical expert panel (TEP) meetings which served as information gathering activities, consistent with the Meaningful Measure Initiative. The TEP consisted of experts in hospice and clinical quality measurement, and it has contributed to development of the HOPE tool and measure concepts since 2019. Based on early TEP input about measure prioritization, measure concept development focused on pain and non-pain symptoms. TEP members noted the importance of measuring the quality of pain and symptom management, as this is a key role of hospice. Through 2020 and 2021, the TEP

provided further feedback on pain and non-pain symptom measure specifications. In Spring 2023, CMS convened the TEP a final time to review the final measure specifications, HOPE Beta test results, and rate face validity of the measure score. The TEP gave strong support for the proposed measure specifications, rated high face validity for these two process measures, and noted the importance of measuring the quality of pain management in hospice care. More information about the TEP meetings and recommendations can be found in the HQRP TEP Reports for 2019-2023, available on the Provider and Stakeholder Engagement webpage. CMS also sought hospice provider input during the HOPE Beta Test to further inform the development of these HOPE-based process measures. During beta testing, registered nurses (RNs) reported that the two-day window of HOPE symptom follow-up aligned with their usual practices.

f. Update on Future Quality Measure (QM) Development

As stated in the FY 2022 Hospice Wage Index final rule (86 FR 42528), we continue to consider developing hybrid quality measures that could be calculated from multiple data sources, such as claims, HOPE data, or other data sources (for example, CAHPS Hospice Survey). To support new measure development, our contractor convened technical expert panel (TEP) meetings in 2022 and 2023. The TEP agreed that CMS should consider applying several risk adjustment factors, such as age and diagnosis, to ensure comparable, representative comparisons between hospices. The TEP also suggested using length of hospice stay but not functional status as risk adjustment factor for hospice performance.

To support new HOPE-based measure development, our contractor convened technical expert panel (TEP) meetings between 2020 and 2023. The TEP recommended specifications for the two HOPE-based quality measures proposed in this Rule – *Timely Follow-Up for Pain Impact* and *Timely Follow-Up for Non-Pain Symptom Impact*. CMS also sought TEP input on several measurement concepts proposed for future quality measure development. Of these measurement concepts, the TEP supported CMS further developing the *Education for Medication Management* and *Wound Management Addressed in Plan of Care* process concepts.

More information about the TEP recommendations can be found in the 2023 HQRP TEP Report, available on the Provider and Stakeholder Engagement webpage. CMS will take the TEP's recommendations under consideration as we continue to develop HOPE-based quality measures.

Additional information about CMS's HOPE-based measure development efforts is available in the 2022-2023 HQRP TEP Summary Report (https://www.cms.gov/files/document/2023-hqrp-tep-summary-report.pdf and the 2023 Information Gathering Report, available on the HQRP Provider and Stakeholder Engagement webpage, or at https://www.cms.gov/files/document/hospicequalityreportingprograminformationgatheringreport2023508.pdf. For further details about the ongoing development of these measures, please visit the Partnership for Quality Measurement website: https://p4qm.org/.

Comment: We received 13 public comments regarding the two HOPE-based process measures. Public comments generally supported the addition of the two proposed HOPE-based QMs.

Several commenters suggested modifications to the measures. One commenter suggested that CMS discontinue the collection of some HIS measures rather than combining them into the HOPE tool. One commenter suggested that CMS standardize the definitions of slight, moderate, and severe symptom impact to improve the reliability of QM data. One commenter requested guidance regarding how hospices should categorize patients whose symptom impact has lessened or stabilized at the time of the follow-up visit. Another commenter suggested that CMS calculate the measures both with and without patients who refused to visit to determine whether visit refusals correlate with other quality concerns.

One commenter requested clarification regarding penalties to hospices for patients who decline a symptom follow-up visit. One comment requested clarification about the start date of HOPE QM public reporting and whether the start date would be based on the Fiscal Year (FY) or the Calendar Year (CY). One commenter requested clarification regarding penalties to hospices

for patients who decline a symptom follow-up visit. Another commenter requested that CMS provide data regarding the proportion of QRP compliant agencies nationally, efforts to improve hospices' ability to report data to CMS, and efforts to enhance transparency to the public. Several commenters requested that CMS delay public reporting of the HOPE-based QMs until 2028 to ensure adequate time for hospices and EMR vendors to implement the measures, as well as sufficient time to collect data and issue provider preview reports.

Some commenters expressed concerns about the new QMs. One comment recommended the measures be further developed before implementation, citing the lack of CBE endorsement. Several comments encouraged CMS to next focus on developing HOPE-based outcome measures, which would add further value to HQRP.

Response: CMS appreciates all public comments regarding the new HOPE-based process QMs. We understand that there are several tools to measure the severity of these symptoms. However, the items for Symptom Impact are not measuring symptom intensity or severity, but rather the impact the patient is experiencing. The Symptom Impact data elements were adapted from an Integrated Palliative Outcome Scale (IPOS) data element that asked about the effect of symptoms on the patient. Please refer to the HOPE development and Testing Report posted on the HOPE webpage for more details: https://www.cms.gov/files/document/hqrp-hospice-outcomes-and-patient-evaluation-hope-development-and-testing-report.pdf. We will continue to provide guidance on this measure, which will be informed by commenters questions and concerns.

CMS is committed to providing hospice providers and vendors with adequate time to implement the new HOPE-based QMs, and intends to support hospices during the transition period. In this final rule, we clarified the timeframes for anticipated public reporting. Additional guidance regarding the new HOPE-based measures will be provided through education and training materials and events leading up to the public reporting of the measures. CMS also intends to continue working with the CBE to ensure that these and future quality measures

meaningfully measure the quality of hospice care and help patients, families, and caregivers to make important hospice decisions.

Comments: We received 15 public comments regarding the time points and burden of the two HOPE-based measures.

Several commenters sought clarification on the number of symptom follow-up visits required and whether the symptom follow-up is allowed at the admission or HUV timepoints. One comment suggested that symptom follow-up should be considered an additional timepoint if it may not be completed during another timepoint.

Several commenters requested that CMS clarify whether the time frame for symptom follow-up will be 48 hours or 2-calendar days. One commenter requested that CMS extend the time frame for follow-up visits. Another commenter appreciated CMS' decision that the symptom follow-up visit cannot be the same as the initial assessment visit, although it can occur in the same day.

Several commenters expressed concerns about the anticipated burden the new measures will add to hospices. Many commenters requested that we allow telehealth or phone visits for symptom follow-up. Two commenters recommended that patients' preference for and tolerance of pain be included in the measures. Two commenters requested that LPNs be allowed to reassess patients' symptom impact. One commenter requested that occupational therapists be included as members of the hospice interdisciplinary team for purposes of the new QMs. One comment suggested that any hospice team member should be allowed to complete the symptom follow-up visit, whether clinical or administrative.

Many comments expressed concern that the symptom follow-up visits (SFV) would create undue burden unless they can be completed via telehealth or phone visits. Two comments highlighted staffing challenges, and several other comments anticipated burdensome costs due to staff training, EMR management, monitoring and oversight, and/or the increased number of

patient visits. One commenter raised concerns that the measures would disproportionately burden rural hospices.

Response: CMS appreciates all comments regarding the new HOPE-based process QMs and their corresponding time points.

At this time, CMS does not believe the symptom follow-up should be considered a unique HOPE time point. Commenters seeking additional guidance regarding the symptom follow-up visits should refer to the HOPE v1.0 Guidance Manual (page 8 and 9), which states that "Depending upon responses to J2051. Symptom Impact, at Admission and the two HUV timepoints, up to three symptom follow-up visits may be required over the course of the hospice stay." The Guidance Manual further states that "Although multiple symptom follow-up visits are not required for the purpose of the HQRP, it is expected that the hospice staff will continue to follow up with the patient, based on their clinical and symptom management needs."

We acknowledge the commenters' recommendation that more hospice team members should be allowed to complete the symptom follow-up visit. Therefore, in this final rule, we have decided that both RNs and LPNs/LVNs may complete the symptom follow-up. At this time, CMS believes it is most appropriate for clinical staff to complete symptom assessments and follow-up visits.

While we understand commenters' concerns about the potential staffing burdens of in-person visits, CMS selected this requirement based on expert input regarding hospice best practices. However, to minimize the burdensome impact of the in-person staffing requirement and to take advantage of the staff members hospices have, we are finalizing a decision that symptom follow-up visits (SFVs) may be performed by either RNs or LPNs/LVNs. We will continue to monitor the provision and burden of in-person HOPE follow-up visits after HOPE implementation and evaluate whether revisions to the HOPE administration requirements are necessary. If modifications to the HOPE instrument are required, they will be proposed in future rulemaking.

Commenters seeking additional guidance regarding the symptom follow-up visits should refer to the HOPE v1.0 Guidance Manual (page 8 and 9), which states that "Depending upon responses to J2051. Symptom Impact, at Admission and the two HUV timepoints, up to three symptom follow-up visits may be required over the course of the hospice stay." The Guidance Manual further states that "Although multiple symptom follow-up visits are not required for the purpose of the HQRP, it is expected that the hospice staff will continue to follow up with the patient, based on their clinical and symptom management needs."

CMS is committed to providing hospice providers and vendors with adequate time to implement the new HOPE-based QMs, and intends to support hospice stakeholders during the transition period. In this final rule, CMS has clarified the time frames for the HOPE-based QMs and anticipated public reporting. Additional guidance regarding the new HOPE-based measures will be provided through education and training materials and events leading up to the public reporting of the measures, anticipated to occur no earlier than November 2027 (FY 2028). CMS also intends to continue working with CBEs to ensure that these and future quality measures meaningfully measure the quality of hospice care and help patients, families, and caregivers to make important hospice decisions.

After considering the public feedback received on the FY 2025 Hospice proposed rule we are finalizing the measures with modifications from the version proposed in the proposed rule. As finalized, theses QMs measure whether patients receive an in-person nursing follow-up visit within 2-calendar days of initial assessment of moderate to severe symptoms impact. Theses (SFVs) may be performed by RNs or LPNs/LVNs. CMS believes that these finalized measures will add value to HQRP. We will continue to monitor measure performance after implementation and will evaluate incoming HOPE data to determine whether to revise the measures in future rulemaking.

3. Hospice Outcomes & Patient Evaluation (HOPE) Assessment Instrument

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.

CMS has developed a new standardized patient level data collection tool, the Hospice Outcomes & Patient Evaluation or HOPE. In past rules, we have described this as a new collection tool, however we believe it is better characterized as a modification of, and functional replacement for, the existing HIS structure.

We proposed and now finalize the decision to begin collecting the HOPE standardized patient level data collection tool on or after October 1, 2025, for quality measures discussed in section III.D.2 of this final rule. The HOPE assessment instrument will replace the HIS upon implementation, as discussed in section III.D.6.(b) of this final rule. In the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), we finalized the instrument name and discussed the primary objectives for HOPE. Specifically, HOPE will provide data for the HQRP quality measures and its requirements through standardized data collection; and provide additional clinical data that could inform future payment refinements. All data collected by the instrument are expected to be used for quality measures, as authorized under section 1814(i)(5)(C) of the Act, and only for quality measures under section 1814(i)(5)(D) of the Act, which will include the measures *Timely Follow-Up for Pain Impact* and *Timely Follow-Up for Non-Pain Symptom Impact* measures finalized in this rule.

HOPE will be a component of implementing high-quality and safe hospice care for patients, Medicare beneficiaries and non-beneficiaries alike. HOPE will also contribute to the patient's plan of care through providing patient data throughout the hospice stay. We finalize the proposal to collect data from multiple time points across the hospice stay, that will inform hospice providers potentially resulting in improved practice and care quality. Additional information about the final HOPE tool v1.0 and the data elements included therein are available

at https://www.cms.gov/medicare/quality/hospice/hope discussed in the Paperwork Reduction Act submission for this collection (CMS-10390).

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

In the FY 2023 Hospice final rule (87 FR 45669), we outlined the testing phases HOPE has undergone, including cognitive, pilot, alpha testing, and national beta field testing. National beta testing, completed at the end of October 2022, allowed us to obtain input from participating hospice teams about the assessment instrument and field testing to refine and support the final items and time points for HOPE. It also allowed us to estimate the time to complete the HOPE elements and establish the interrater reliability of each item. For additional details and results from HOPE testing, see the HOPE Testing Report, available in the Downloads section of the HOPE page of the HQRP website.

CMS will adopt and implement HOPE as a standardized patient element set to replace the current Hospice Item Set (HIS). Relative to HIS, HOPE includes new items in several domains that are new or expanded (Sociodemographic, Living Arrangements, Availability of Assistance, Diagnoses, Symptom Impact Assessment, Imminent Death, Skin), and includes an additional timepoint (the Hospice Update Visit, or HUV).

HOPE v1.0 will contain demographic, record processing, and patient-level standardized data elements that will be collected by all Medicare-certified hospices for all patients, regardless of payer source or patient age, to support HQRP quality measures. New HOPE data elements will be collected in real-time to assess patients based on the hospice's interactions with the patient and family/caregiver, accommodate patients with varying clinical needs, and provide additional information to contribute to the patient's care plan throughout the hospice stay (not just at admission and discharge). These data elements represent domains such as Administrative, Preferences for Customary Routine Activities, Active Diagnoses, Health Conditions, Medications, and Skin Conditions. HOPE data will be collected by hospice staff for each patient admission at three distinct time points: admission, the hospice update visit (HUV), and discharge, as discussed in the PRA as well as sections IV.A and V of this final rule in which we discuss Collection of Information requirements and the Regulatory Impact Analysis. We finalize the timepoint for the HOPE Update Visits (HUV), which is dependent on the patient's length of stay (LOS), is limited to a subset of HOPE items addressing clinical issues important to the care of hospice patients as updates to the hospice plan of care. HOPE data will be collected at these timepoints during the hospice's routine clinical assessments, based on unique patient assessment visits and additional follow-up visits as needed. As further discussed in the finalized HOPE Guidance Manual and PRA, not all HOPE items will be required to be completed at every timepoint. These time points could also be revised in future rulemaking.

HOPE data reporting and collection will be effective beginning on or after October 1, 2025 to support the quality measures anticipated for public reporting on or after FY 2028. After HOPE implementation, hospices will no longer need to collect and submit the Hospice Item Set (HIS). Additional details regarding the data collection required for the new HOPE item set are discussed in section III.D.6, "Form, Manner, and Timing of Quality Measure Data Submission", and section IV, "Collection of Information."

We are finalizing updates § 418.312(a)(b)(1) to require hospices to complete and submit a standardized set of items for each patient to capture patient-level data, regardless of payer or patient age. This change will take effect October 1, 2025. This update will replace the previous requirement for hospices to complete the HIS and the newly standardized set of items will have to be completed at admission and discharge, and at the two HUV timepoints within the first 30 days after the hospice election. We note that, as authorized under section 1814(i)(5) of the Act, CMS would impose a 4 percent reduction on hospices for failure to submit HOPE collections timely with respect to that FY.

CMS is committed to ensuring hospices are ready for the data reporting and collection beginning on or after October 1, 2025. We will provide information about upcoming provider trainings related to HOPE v1.0 that will be posted on the CMS HQRP website[8] on the Announcement and Spotlight[9] page and announced during Open Door Forums. Past trainings about the HQRP are available through the HQRP Training and Education Library.[10] These trainings will help providers understand the requirements necessary to be successful with the HQRP, including how data collected via the new HOPE tool is submitted for quality measures and contributes to compliance with the HQRP.

The final HOPE Guidance Manual v1.0 will be available on the HQRP HOPE webpage after the publication of the final rule. This guidance manual offers hospices direction on the collection and submission of hospice patient stay data to CMS to support the HQRP quality measures.

Public Availability of Data Submitted

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any quality measure data submitted by hospices available to the public. The

8 https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospice-quality-reporting
9 https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospice-quality-reporting/spotlight
10 https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospice-quality-reporting/hospice-quality-reporting-training-training-and-education-library

procedures ensure that a hospice will have the opportunity to review the data regarding the hospice's respective program before it is made public. In addition, under section 1814(i)(5)(E) of the Act, the Secretary is authorized to report data collected to support quality measures under section 1814(i)(5)(C) of the Act on the CMS Web site, that relate to services furnished by a hospice. We recognize that public reporting of quality measure data is a vital component of a robust quality reporting program and are fully committed to developing the necessary systems for public reporting of hospice quality measure data. We also recognize it is essential that the data made available to the public be meaningful and that comparing performance between hospices requires that measures be constructed from data collected in a standardized and uniform manner. The development and implementation of a standardized data set for hospices should precede public reporting of hospice quality measures. Once hospices have implemented the standardized data collection approach, we will have the data needed to establish the scientific soundness of the quality measures that can be calculated using the standardized data. It is critical to establish the reliability and validity of the measures prior to public reporting in order to demonstrate the ability of the measures to distinguish the quality of services provided. To establish reliability and validity of the quality measures, at least four quarters of data will need to be analyzed. Typically, the first two quarters of data reflect the learning curve of the providers as they adopt a standardized data collection; these data are not used to establish reliability and validity. We are finalizing the decision that the data from the first quarter Q4 CY 2025, if HOPE data collection begins in October 2025, it will not be used for assessing validity and reliability of the quality measures.

We will assess the quality and completeness of the data that we receive as we near the end of Q4 2025 before public reporting the measures. Data collected by hospices during the four quarters of CY 2026 (for example, Q 1, 2, 3 and 4 CY 2026) will be analyzed starting in CY 2027. We will inform the public of the decisions about whether to report some or all of the quality measures publicly based on the findings of analysis of the CY 2026 data.

In addition, as noted, the Affordable Care Act requires that reporting on the quality measures adopted under section 1814(i)(5)(D) of the Act be made public on a CMS Web site and that providers have an opportunity to review their data prior to public reporting. In light of all the steps required prior to data being publicly reported, we finalize the decision that public reporting of the proposed quality measures will be implemented no earlier than FY 2028, allowing ample time for data analysis, review of measures' appropriateness for use for public reporting, and allowing hospices the required time to review their own data prior to public reporting.

CMS will consider public reporting using fewer than four (4) quarters of data for the initial reporting period, but we are finalizing the decision to use 4 quarters of data as the standard reporting period for future public reporting. If the initial reporting period would include any excluded quarters of data, we will use as many non-excluded quarters of data as are included in the reporting period for public reporting. For example, if the first reporting period includes Q4 2025 through Q3 2026, then public reporting of HOPE will be based on Q1 2026, Q2 2026, and Q3 2026. The next public reporting period would include Q1 2026 – Q4 2026, and public reporting would be based on four (4) quarters of data, as would all subsequent rolling reporting periods.

Comment: We received 43 comments related to the HOPE instrument. Most commenters supported the implementation of the HOPE tool as a replacement for HIS and commended CMS's efforts to improve data collection and enhance the quality of care for patients. However, those in support of the HOPE tool expressed a variety of concerns with the HOPE instrument proposal. A majority of commenters asked for CMS to allow both HOPE assessments and reassessments to be completed via telehealth, as well as allow any member of the IDG to complete the assessments, to reduce the burden of in-patient visits. Most commenters also asked for a delay in implementation, ranging from July 2025 to FY 2027, to account for the need to implement new staff training, system updates, and additional staffing. This delay would also

allow EMR vendors to update their systems to account for the new instrument. In relation, some commenters also asked for a phased approach rather than requiring hospices to reach the 90 percent threshold immediately upon implementation or allow a "pilot" period to test out the new processes and instrument. Some commenters also expressed concern that the burden estimates did not seem to reflect the total additional clinical and administrative costs that would be incurred by implementing the HOPE instrument.

Other commenters requested clarifications regarding the assessments and instrument items. One of the most common requests for clarification is whether the HOPE assessment needs to be completed for all patients or only those over the age of 18. Many commenters also sought clarification around the timing associated with the symptom follow-up visits – whether it is 48 hours or two calendar days. Other questions included how long the symptom follow-up visits should continue, if the admission and comprehensive assessment can be done on the same visit, and how the date for completing the assessment and symptom follow-up visits should be entered.

Some commenters recommended modifications to the HOPE instrument. One commenter felt that HOPE should assess the spiritual and psychosocial aspects of the hospice experience. A few comments mentioned specific data elements included in the HOPE tool. One noted the item A1805, "Admitted From and thought it should be revised to name the referral source. There were also several clarifications suggested for some of the new items.

Many commenters mentioned that the instrument, as it exists now, contains only process measures and they urged CMS to consider adding outcome measures in the future. Some commenters also suggested that CMS monitor and evaluate the measures post-implementation to ensure the validity of the data and that providers aren't "manipulating" the data to their benefit when possible. Finally, regarding public reporting, some commenters sought clarification on how many quarters will be excluded and if providers will be able to preview the data before it is publicly reported.

Response: CMS appreciates all stakeholders' input regarding the new HOPE instrument. In this final rule, we have clarified the timing and requirements for pain and non-pain symptom follow-up visits, which must be completed within 2 calendar days of an initial assessment. Commenters seeking additional guidance regarding the pain and non-pain symptom follow-up visits should refer to the HOPE v1.0 Guidance Manual (page 8 and 9), which states that "Depending upon responses to J2051. Symptom Impact, at Admission and the two HUV timepoints, up to three symptom follow-up visits may be required over the course of the hospice stay." The Guidance Manual further states that "Although multiple symptom follow-ups are not required for the purpose of the HQRP, it is expected that the hospice staff will continue to follow up with the patient, based on their clinical and symptom management needs."

A few comments mentioned specific data elements included in the HOPE tool. With respect to the comment regarding item A1805, "Admitted From" and the suggestion that this be revised to name the referral source,[11] we note that this item, along with many others, has been included in the HIS since 2014, and while there are several new items in HOPE, many are original and have not changed, or include only minor adjustments for HOPE. There were also several clarifications suggested for some of the new items, such as A1110. Language, I0010. Principle Diagnosis, and J0915. Neuropathic pain.[12] CMS will consider these suggestions prior to finalizing the HOPE Instrument v1.0. In creating HOPE, CMS carefully considered the fact that many hospice patients are unable to directly report and for that reason chose to create items which rely on the clinical judgment of the assessing nurse after observing and interviewing the

[11] A1805 replaces a similar item (A1802) that has been included in the Hospice Item Set (HIS) since its inception in 2014. The change was made to use 1805 in order to align across settings as this item is in use in the SNF setting.
[12] A2220 Language is a cross-setting item and currently in use in the other PAC settings. This has been added to HOPE to assist hospice providers and CMS in understanding the language needs of hospice patients and their families. I0010 Principle Diagnosis is the primary terminal diagnosis for which the patient is being referred to hospice. All care related to the primary hospice diagnosis is expected to be covered under the Medicare Hospice Benefit (MHB). J0915 Neuropathic pain has been added to HOPE for possible risk adjustment in future outcome quality measures that measure improvement in symptoms. Neuropathic pain is unique and unlike other types of pain can take more time and be much more difficult to successfully treat and improve.

patient as well as the family/caregiver. This flexibility will allow more hospice patient data to be included in the HQRP.

During the development of HOPE, CMS considered how to capture data that could reflect the quality of the spiritual and psychosocial aspects of the hospice experience. For more information about the results of these development efforts, please refer to the HOPE Beta Testing Report, available at: https://www.cms.gov/files/document/hqrp-hospice-outcomes-and-patient-evaluation-hope-development-and-testing-report.pdf

While we understand commenters' concerns about the potential staffing burdens of in-person visits, CMS selected this requirement based on expert input regarding hospice best practices. We will continue to monitor the provision and burden of in-person HOPE follow-up visits after HOPE implementation and evaluate whether revisions to the HOPE administration requirements are necessary. If modifications to the HOPE instrument are required, they will be proposed in future rulemaking.

CMS also reminds commenters that the burden calculations associated with HOPE only reflect the costs of implementation and administration of the HOPE assessment instrument, and do not include costs hospices may incur associated with visits to patients. This calculation methodology is consistent with the current HIS instrument. Additionally, the HOPE burden calculations represent incremental or additional costs hospices will incur in addition to the existing costs associated with HIS, as HOPE will replace HIS once implemented. Therefore, any costs hospices currently incur administering HIS will still be incurred but will not be the direct result of implementation of HOPE. We will continue to monitor the cost impact of HOPE after implementation.

CMS is committed to providing hospice providers and vendors with adequate time to implement the new HOPE instrument and intends to support hospice stakeholders during the transition period. Additional guidance regarding the new HOPE-based measures will be provided through education and training materials and events leading up to the implementation

of the instrument in October 2025. Providers will have the opportunity to preview HOPE data before it is publicly reported, with the first HOPE-based QM public reporting anticipated to be no earlier than November 2027 (FY 2028).

We recognize commenters' concerns that there will not be a phased approach for the 90 percent reporting threshold as there was with HIS. CMS remains committed to providing hospice providers and vendors with adequate time to implement these provisions. Because hospices already have a 90 percent reporting threshold for HIS and HOPE builds on the foundations of HIS, we anticipate that hospices will be able to continue meeting the 90 percent reporting threshold after HOPE implementation.

Additional guidance regarding the new HOPE-based measures will be provided through education and training materials and events leading up to the public reporting of the measures, anticipated to occur no earlier than November 2027 (FY 2028). CMS also intends to continue working with CBEs to ensure that these and future quality measures meaningfully measure the quality of hospice care and help patients, families, and caregivers to make important hospice decisions.

CMS appreciates commenters' recommendations to develop HOPE-based outcome measures. We intend to continue to develop HOPE-based outcome measures to add to HQRP to increase the value of the quality data collected and reported by the program.

Comment: We received 21 public comments related to the HUV timepoints. Many comments expressed concern that the HUV timepoints would create undue burden unless it can be completed via telehealth or phone visits. One comment suggested that CMS should add a third HUV timepoints at the first patient recertification and start of their second benefit period.

One comment suggested revising the items included in the HUV timepoints to omit some administrative items, while adding items that may enhance hospices' ability to evaluate health equity, such as Living Arrangement, Availability of Assistance, and Preferences for Customary Routine and Activities.

Several comments sought clarification on the HOPE submission rate and whether the HUV may be conducted at the same visit as updates to the comprehensive assessment. Two comments expressed concern that the cost burden estimates in the proposed rule were unrealistic in light of the amount of additional data collection and newly required visits.

Response: CMS appreciates all stakeholders' input regarding the HUV timepoints. While we understand commenters' concerns about the potential staffing burdens of in-person visits, CMS selected this requirement based on expert input regarding hospice best practices. We will continue to monitor the provision and burden of in-person HOPE follow-up visits after HOPE implementation and evaluate whether revisions to the HOPE administration requirements are necessary. If modifications to the HOPE instrument are required, they will be proposed in future rulemaking.

CMS also reminds commenters that the burden calculations associated with HOPE only reflect the costs of implementation and administration of the HOPE assessment instrument, and do not include costs hospices may incur associated with visits to patients. This calculation methodology is consistent with the current HIS instrument. Additionally, the HOPE burden calculations represent incremental or additional costs hospices will incur in addition to the existing costs associated with HIS, as HOPE will replace HIS once implemented. Therefore, any costs hospices currently incur administering HIS will still be incurred but will not be the direct result of implementation of HOPE. We will continue to monitor the cost impact of HOPE after implementation to determine whether adjustments to the HUV are necessary.

Likewise, CMS will continue to evaluate HOPE after implementation to determine whether items should be added to or removed from the HUV timepoints. While CMS considered a third timepoints and more, the current HOPE v1.0 is a start to collecting more useful data during the hospice stay for the HQRP. This input may be considered for future versions of HOPE.

Comment: We received 5 public comments related to CMS' future quality measure development efforts. Commenters were generally supportive of CMS's ongoing measure development efforts. Several commenters suggested additional measure concepts for CMS consideration, including patients' access to hospice teams, ensuring that hospices can provide all four levels of hospice care, and patients' ability to manage their own health care. One commenter encouraged CMS to include the entire hospice team in the measure assessment and outcomes plan development, including occupational therapy.

Response: CMS appreciates all stakeholders' input regarding ongoing and future quality measure development. We will take all public comments into consideration as we select measure development priorities. We intend to continue to develop HOPE-based outcome measures to add to HQRP to increase the value of the quality data collected and reported by the program. Additional information regarding quality measure development will be provided in future rulemaking.

4. Health Equity Updates related to HQRP

a. Background

Universal Foundation

To further the goals of the CMS National Quality Strategy (NQS), CMS leaders from across the Agency have come together to move towards a building-block approach to streamline quality measures across CMS quality programs for the adult and pediatric populations. We believe that this "Universal Foundation" of quality measures will focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. The development and implementation of the Preliminary Adult and Pediatric Universal Foundation Measures will promote the best, safest, and most equitable care for individuals. As CMS moves forward with the Universal Foundation, we will be working to identify foundational

measures in other specific settings and populations to support further measure alignment across CMS programs as applicable.

TEP Recommendations

In November and December 2022, CMS convened a group of stakeholders to provide input on the health equity measure development process. This HQRP and HH QRP Health Equity Structural Composite Measure Development Technical Expert Panel (or Home Health & Hospice HE TEP) included health equity experts from hospice and home health settings specializing in quality assurance, patience advocacy, clinical work, and measure development.

The TEP largely supported the potential health equity measure domains of Equity as a Key Organizational Priority, Trainings for Health Equity, and Organizational Culture of Equity. The TEP also recommended that CMS not only measure equity in service provision, but also equity in access to services. TEP members raised concerns about collecting hospice quality measure data from family or caregivers of hospice decedents rather than collecting data directly from patients while they are receiving care. Vulnerable populations without contacts post-mortem may be left out of data collection, such as hospice patients who do not have family members to help with their care or unhoused people. This feedback highlighted the importance of including SDOH such as housing instability in hospice quality reporting. Hospice TEP members also recommended adding specific questions to the CAHPS® survey about cultural sensitivity.

Additional information regarding the Home Health & Hospice HE TEP are available in the TEP Report, available on the Hospice QRP Health Equity webpage at https://www.cms.gov/medicare/quality/hospice/hospice-qrp-health-equity.

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

CMS is committed to developing approaches to meaningfully incorporate the advancement of health equity into the HQRP. One consideration is including social determinants

of health (SDOH) into our quality measures and data stratification. SDOH are the socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health. SDOH can be grouped into five broad domains: economic stability; education access and quality; health care access and quality; neighborhood and built environment; and social and community context. Health-related social needs (HRSNs) are the resulting effects of SDOH, which are individual-level, adverse social conditions that negatively impact a person's health or health care. Examples of HRSN include lack of access to food, housing, or transportation, and have been associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs. Certain HRSNs can lead to unmet social needs that directly influence an individual's physical, psychosocial, and functional status. This is particularly true for food security, housing stability, utilities security, and access to transportation. In recent years, we have addressed SDOH through the identification and standardization of screening for HRSN, including finalizing several standardized patient assessment data requirements for post-acute care providers[13] and testing the Accountable Health Communities (AHC) model under section 1115A of the Social Security Act.[14]

[13] See the "Medicare and Medicaid Programs: CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements" final rule (84 FR 39151) as an example. In the interim final rule with comment period (IFC) "Medicare and Medicaid Programs, Basic Health Program and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program" (85 FR 27550 through 27629), CMS delayed the compliance dates for these standardized patient assessment data under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), Long-Term Care Hospital (LTCH) QRP, Skilled Nursing Facility (SNF) QRP, and the Home Health (HH) QRP due to the public health emergency. In the "CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Model Expansion; Home Health and Other Quality Reporting Program Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; and COVID–19 Reporting Requirements for Long-Term Care Facilities" final rule (86 FR 62240 through 62431), CMS finalized its proposals to require collection of standardized patient assessment data under the IRF QRP and LTCH QRP effective October 1, 2022, and January 1, 2023, for the HH QRP.

[14] The Accountable Health Communities Model is a nationwide initiative established by the Center for Medicare and Medicaid Innovation Center to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, and Children's Health Insurance Program expenditures while maintaining or enhancing the quality of beneficiaries care and was based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs. More information can be found at: https://www.cms.gov/priorities/innovation/innovation-models/ahcm.

We have repeatedly heard from the public that CMS should develop new HQRP mechanisms to better address significant and persistent health care outcome inequities. For example, in the FY 2022 Hospice Wage Index final rule, we received comments supportive of gathering standardized patient assessment data elements and additional SDOH data to improve health equity. In the FY 2023 Hospice final rule, we again received comments highlighting the need for more sociodemographic and SDOH data to effectively evaluate health equity in hospice settings. Commenters suggested that CMS consider standardizing the sociodemographic and SDOH data collected across provider settings and across third party vendors (for example, EMRs) and other tools. To this end, CMS expects to seek endorsement by the CBE contracted with CMS under section 1890(a) of the Act for measures that would utilize SDOH data within HQRP.

We are committed to achieving health equity in health care outcomes for our beneficiaries, including by improving data collection to better measure and analyze disparities across programs and policies.[15] We believe that the ongoing measurement of SDOHs will have two significant benefits. First, because SDOHs disproportionately impact underserved communities, promoting measurement of these factors may serve as evidence-based building blocks for supporting healthcare providers and health systems in actualizing commitment to address disparities, improving health equity through addressing the social needs with community partners, and implementing associated equity measures to track progress.[16] By measuring patient SDOH providers would be better equipped to identify disparities in patient populations and health outcomes. Better SDOH quality measures would serve as evidence-based building blocks for informing more effective programs to target and mitigate disparities, thereby enabling providers to improve patient outcomes.

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[15] Centers for Medicare & Medicaid Services. CMS Quality Strategy. 2016. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf

[16] American Hospital Association. (2020). Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards. December 2020. Accessed: January 18, 2022. Available at: https://ifdhe.aha.org/system/files/media/file/2020/12/ifdhe_inclusion_dashboard.pdf.

Second, these factors could support ongoing HQRP initiatives by providing data with which to measure stratified resident risk and organizational performance. Further, we believe measuring resident-level SDOH through screening is essential in the long-term in encouraging meaningful collaboration between healthcare providers and community-based organizations, as well as in implementing and evaluating related innovations in health and social care delivery. Analysis of SDOH measures could allow providers to more effectively identify patient needs and identify opportunities for effective partnership with community-based organizations with the capacity to help address those needs. Thorough SDOH measures would also provide a better evidence base for evaluating the effectiveness and appropriateness of health and social care delivery innovations. The SDOH category of standardized patient assessment data elements could provide hospices and policymakers with meaningful measures as we seek to reduce disparities and improve care for beneficiaries with social risk factors. SDOH measures would also permit us to develop the statistical tools necessary to reduce costs and improve the quality of care for all beneficiaries. We note that advancing health equity by addressing the health disparities that underlie the country's health system is one of our strategic pillars[17] and a Biden-Harris Administration priority.[18] As such, CMS is working toward collecting SDOH data elements in hospice in support of quality measurement and seeks public comment on these efforts.

CMS reviewed SDOH domains to determine which domains align across post-acute care (PAC) and hospice care settings, circumstances, and setting-specific care goals. CMS identified four SDOH domains that are relevant across the PAC and hospice care setting: housing instability, food insecurity, utility challenges, and barriers to transportation access. These data elements have supported measures of quality in other settings. For example, as of 2023 the

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[17] Brooks-LaSure, C. (2021). My First 100 Days and Where We Go from Here: A Strategic Vision for CMS. Centers for Medicare & Medicaid. Available at: *https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms.*

[18] The White House. The Biden-Harris Administration Immediate Priorities [website]. https://www.whitehouse.gov/priorities/

Hospital Inpatient Quality Reporting Program mandates reporting on the "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" measures.

These SDOH are important to consider for all patients, however they may manifest differently for patients in hospice compared to other care settings. For example, HRSNs such as housing instability and utilities challenges may be especially problematic for hospice patients in home-based hospice care, which comprises most hospice care.[19] In contrast, other HRSNs may seem less relevant for hospice patients but may still influence the end-of-life outcomes in different ways. For example, compared to other settings, food insecurity may not be as common an issue for EOL patients, who typically have reduced needs for food and water. However, caregiver experiences of food insecurity may have important consequences on their ability to carry out their caregiving responsibilities. Therefore, CMS requested input on which of the existing HRSN data collection items outlined below are suitable for the hospice setting, and how they may need to be adapted to be more appropriate for the hospice setting.

Housing Instability

Healthy People 2030 prioritizes economic stability as a key SDOH, of which housing stability is a component.[20,21] Lack of housing stability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing.[22] These experiences may negatively affect physical health and make it harder to access health care. Lack of housing stability can also lead to homelessness, which is housing deprivation in its most severe form. The United States Department of Housing and Urban Development (HUD) defines literal homelessness as "lacking a fixed regular, and

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[19] Tucker-Seeley, R.D., Abel, G.D., Uno, H., & Prigerson, H. (2014). Financial hardship and the intensity of medical care received near death. *Psychooncology,24*(5):572–8. doi: 10.1002/pon.3624.

[20] https://health.gov/healthypeople/priority-areas/social-determinants-health

[21] Healthy People 2030 is a long-term, evidence-based effort led by the U.S. Department of Health and Human Services (HHS) that aims to identify nationwide health improvement priorities and improve the health of all Americans.

[22] Kushel, M. B., Gupta, R., Gee, L., & Haas, J. S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of General Internal Medicine*, *21*(1), 71–77. doi: 10.1111/j.1525-1497.2005.00278.x

adequate nighttime residence."[23] On a single night in 2023, roughly 653,100 people, or 20 out of every 10,000 people in the United States, were experiencing homelessness.[24] Studies also found that newly homeless people have an increased risk of premature death and experience chronic disease more often than among the general population.

The following options were identified as potential complimentary items to collect housing information, in addition to proposed HOPE item A1905 - Living Arrangements.

Exhibit I. Potential Items to Screen for Housing Instability in Hospice

Tool	Item	Response Options	Source
Accountable Health Communities Health Related Social Needs (AHC HRSN)	Think about the place you live. Do you have problems with any of the following?	a. Pests such as bugs, ants, or mice b. Mold c. Lead paint or pipes d. Lack of heat e. Oven or stove not working f. Smoke detectors missing or not working g. Water leaks h. None of the above	https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
Protocol for Responding to & Assessing Patients' Assets, Risks & Experience	Are you worried about losing your housing?	a. Yes b. No c. I choose not to answer this question	https://prapare.org/wp-content/uploads/2023/01/PRAPARE-English.pdf

Food Insecurity

The U.S. Department of Agriculture, Economic Research Service defines a lack of food security as a household-level economic and social condition of limited or uncertain access to adequate food.[25] Food insecurity has been a priority for the Biden-Harris Administration, with the White House recently announcing 141 stakeholder funding commitments to support the

[23] https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/category-1/

[24] The 2023 Annual Homeless Assessment Report (AHAR) to Congress. The U.S. Department of Housing and Urban Development 2023. https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf.

[25] U.S. Department of Agriculture, Economic Research Service. (n.d.). *Definitions of food security*. Retrieved March 10, 2022, from https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/

White House Challenge to End Hunger and Build Healthy Communities.[26] Adults who are food insecure may be at an increased risk for a variety of negative health outcomes and health disparities. For example, a study found that food-insecure adults may be at an increased risk for obesity.[27] Nutrition security is also an important component that builds on and complements long standing efforts to advance food security. The United States Department of Agriculture (USDA) defines nutrition security as "consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-being."[28] While having enough food is one of many predictors for health outcomes, a diet low in nutritious foods is also a factor.[29] Studies have shown that older adults struggling with food security consume fewer calories and nutrients and have lower overall dietary quality than those who are food secure, which can put them at nutritional risk. Older adults are also at a higher risk of developing malnutrition, which is considered a state of deficit, excess, or imbalance in protein, energy, or other nutrients that adversely impacts an individual's own body form, function, and clinical outcomes. Up to 50 percent of older adults are affected by or at risk for malnutrition, which is further aggravated by a lack of food security and poverty.[30]

Exhibit II. Potential Items to Screen for Food Insecurity in Hospice

Tool	Item	Response Options	Source
Health Begins - Upstream Risk Screening Tool	Which of the following describes the amount of food your household has to eat: (Check one.)	a. Enough to eat b. Sometimes not enough to eat	https://www.aamc.org/media/25736/download

[26] https://www.whitehouse.gov/briefing-room/statements-releases/2024/02/27/fact-sheet-the-biden-harris-administration-announces-nearly-1-7-billion-in-new-commitments-cultivated-through-the-white-house-challenge-to-end-hunger-and-build-healthy-communities/

[27] Hernandez, D. C., Reesor, L. M., & Murillo, R. (2017). Food insecurity and adult overweight/obesity: Gender and race/ethnic disparities. *Appetite, 117,* 373–378.

[28] Food and Nutrition Security. (n.d.). USDA. https://www.usda.gov/nutrition-security

[29] National Center for Health Statistics. (2022, September 6). Exercise or Physical Activity. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/nchs/fastats/exercise.htm

[30] Food Research & Action Center (FRAC). "Hunger is a Health Issue for Older Adults: Food Security, Health, and the Federal Nutrition Programs." December 2019. https://frac.org/wp-content/uploads/hunger-is-a-health-issue-for-older-adults-1.pdf

Tool	Item	Response Options	Source
		c. Often not enough to eat	
Hunger Vital Sign	1. Within the past 12 months we worried whether our food would run out before we got money to buy more.	a. Often true b. Sometimes true c. Never true	https://childrenshealthwatch.org/public-policy/hunger-vital-sign/
	2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.	a. Often true b. Sometimes true c. Never true	
Children's HealthWatch	In the past year, have you ever used a Food Pantry/Soup Kitchen or received a food donation?	Yes No	http://childrenshealthwatch.org/public-policy/hunger-vital-sign/

Utility Insecurity

A lack of energy (utility) security can be defined as an inability to adequately meet basic household energy needs.[31] According to the Department of Energy, one in three households in the US are unable to adequately meet basic household energy needs.[32] The consequences associated with a lack of utility security are represented by three primary dimensions: economic, physical, and behavioral. Individuals with low incomes are disproportionately affected by high energy costs, and they may be forced to prioritize paying for housing and food over utilities. Some people may face limited housing options and are at increased risk of living in lower-quality physical conditions with malfunctioning heating and cooling systems, poor lighting, and outdated plumbing and electrical systems. Finally, individuals who lack of utility security may use negative behavioral approaches to cope, such as using stoves and space heaters for heat.[33] In addition, data from the Department of Energy's US Energy Information Administration confirm that a lack of energy security disproportionately affects certain populations, such as low-income

[31] Hernández D. Understanding 'energy insecurity' and why it matters to health. Soc Sci Med. 2016 Oct; 167:1-10. doi: 10.1016/j.socscimed.2016.08.029. Epub 2016 Aug 21. PMID: 27592003; PMCID: PMC5114037.
[32] US Energy Information Administration. "One in Three U.S. Households Faced Challenges in Paying Energy Bills in 2015." 2017 Oct 13. https://www.eia.gov/consumption/residential/reports/2015/energybills/
[33] Hernández D. "What 'Merle' Taught Me About Energy Insecurity and Health." Health Affairs, VOL.37, NO.3: Advancing Health Equity Narrative Matters. March 2018. https://doi.org/10.1377/hlthaff.2017.1413

and African American households.[34] The effects of a lack of utility security include vulnerability to environmental exposures such as dampness, mold, and thermal discomfort in the home, which have direct effect on residents' health. For example, research has shown associations between a lack of energy security and respiratory conditions as well as mental health–related disparities and poor sleep quality in vulnerable populations such as older adults,, children, the socioeconomically disadvantaged, and the medically vulnerable.[35] Adopting a data element to collect information about utility security across PAC settings could facilitate the identification of residents who may not have utility security and who may benefit from engagement efforts.

Exhibit III. Potential Items to Screen for Utility Challenges in Hospice

Tool	Item	Response Options	Source
North Carolina Medicaid Screening Tool	Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?	Yes No	https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions
WELL RX Toolkit	Do you have trouble paying for your utilities (gas, electricity, phone)?	Yes No	https://sirenetwork.ucsf.edu/tools-resources/resources/wellrx-toolkit
Health Leads - Social Needs Screening Toolkit	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	Yes No	https://healthleadsusa.org/wp-content/uploads/2023/05/Screening_Toolkit_2018.pdf

Transportation Needs

Transportation barriers can both directly and indirectly affect a person's health. A lack of transportation can keep patients from accessing medical appointments, getting medications, or from getting things they need daily. It can also affect a person's health by creating a barrier to

[34] US Energy Information Administration. "One in Three U.S. Households Faced Challenges in Paying Energy Bills in 2015." 2017 Oct 13. https://www.eia.gov/consumption/residential/reports/2015/energybills/

[35] Hernández D. "Understanding 'energy insecurity' and why it matters to health." Soc Sci Med. 2016; 167:1-10.

accessing goods and services, obtaining adequate food and clothing, or attending social activities. Therefore, reliable transportation services are fundamental to a person's health.

Exhibit IV. Potential Items to Screen for Transportation Challenges in Hospice

Tool	Item	Response Options	Source
AHC HRSN	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes No	https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
Borders	Are you regularly able to get a friend or relative to take you to doctor's appointments?	Yes No	https://oaktrust.library.tamu.edu/bitstream/handle/1969.1/6016/etd-tamu-2006A-URSC-Borders.pdf

All Domains

Exhibit V. Potential Items to Screen for All Domains

Tool	Item	Response Options	Source
Kaiser Permanente's Your Current Life Situation Survey	In the past 3 months, did you have trouble paying for any of the following?	a. Food b. Housing c. Heat and electricity d. Medical needs e. Transportation f. Childcare g. Debts h. Other i. None of these	https://sirenetwork.ucsf.edu/sites/default/files/Your%20Current%20Life%20Situation%20Questionnaire%20v2-0%20%28Core%20and%20supplemental%29%20no%20highlights.pdf

We solicited public comment on the following questions:

- For each of the domains:

++ Are these items relevant for hospice patients? Are these items relevant for hospice caregivers?

++ Which of these items are most suitable for hospice?

++ How might the items need to be adapted to improve relevance for hospice patients and their caregivers? Would you recommend adjusting the listed timeframes for any items? Would you recommend revising any of the items' response options?

- Are there additional SDOH domains that would also be useful for identifying and addressing health equity issues in Hospice?

Comment: We received 39 public comments related to the RFI on health equity and SDOH. The majority of commenters were supportive of including sociodemographic and SDOH data to evaluate health equity in the hospice setting. The same majority supported the inclusion of the four proposed domains, while offering insights into what they felt was most relevant within each domain and what additional factors or questions CMS should consider within each domain (for example, for food insecurity, thinking about nutritional supplements for those who no longer consume food in traditional ways; for transportation item, focusing on caregiver transportation needs to enhance their ability to support the beneficiary).

Several commenters expressed concern with how the collected SDOH data will be, or should be, used by hospices. They encouraged CMS to establish clear expectations on how hospices should utilize the data to improve patient care and address patient needs. They felt it was important that the data be used, and not just collected. Similarly, several commenters recommended that SDOH data collection must be coupled with provider education, adequate resources, and community networks that would allow agencies to effectively address SDOH needs, improve quality of care, and achieve health equity. Some commenters also mentioned concerns around the burden associated with collecting this additional data, especially considering the short length of stays many hospice patients experience. There were suggestions to allow the data to be gathered from pre-existing sources, such as EHRs from PCPs or standardized SDOH data elements used in other healthcare settings, as well as allowing the data to be collected through observation, in addition to talking with the patient and/or caregivers.

Other commenters made additional suggestions, such as including the response option, "I choose not to answer this question," for all SDOH questions for those who are reluctant or refuse to answer a question and reducing the time window listed in some questions to allow the hospice provider to pinpoint more pressing needs and to take into account the shorter length of stay of most hospice beneficiaries (for example, considering the past 3 or 6 months rather than the past 12 months). Several commenters also noted that adaptations of the SDOH items may be necessary to account for differences in facility versus home-based hospice care.

Lastly, suggestions for additional domains for consideration included: the presence of a caregiver, economic stability, criminal history, access to a PCP, education levels, preferred language, religion, gender identity, exposure to adverse weather events, safety of foods being consumed (for example, expired goods), home accessibility, and health literacy. A few commenters suggested specific tools, such as the Use of Area Deprivation Index (ADI), a Needs Navigation model, and the Accountable Health Communities Health Related Social Needs Screening Tool.

Response: CMS appreciates all stakeholders' input regarding the potential inclusion of additional SDOH items in HQRP, among other efforts to improve hospice health equity. We will consider this input on the proposed and other recommended potential SDOH items in HQRP as we continue work to develop and work towards implementation of these data elements.

5. CAHPS Hospice Survey and Measure Changes

a. Survey and Measure Changes

In the Fiscal Year 2024 Hospice Payment Rate Update final rule (88 FR 51164), CMS provided the results of a mode experiment conducted with 56 large hospices in 2021. The experiment tested a web-mail mode, modification to survey administration protocols such as adding a prenotification letter and extending the data collection period, and a revised survey version. Because we believe the results of the experiment were successful, we are finalizing changes to the CAHPS Hospice Survey and administrative protocol. The revised survey is

shorter and simpler than the current survey and includes new questions on topics suggested by stakeholders. Specifically, finalized changes to the survey and the quality measures derived from testing include:

- Removal of three nursing home items and an item about moving the family member[36] that are not included in scored measures.
- Removal of one survey item regarding confusing or contradictory information from the Hospice Team Communication measure[37]
- Replacement of the multi-item Getting Hospice Care Training measure[38] with a new, one-item summary measure.
- Addition of two new items, which will be used to calculate a new Care Preferences measure.
- Simplified wording to component items in the Hospice Team Communication, Getting Timely Care, and Treating Family Member with Respect measures.

The revised CAHPS Hospice Survey, including the new Care Preferences measure, the revised Hospice Team Communication measure, and the revised Getting Hospice Care Training measure received endorsement through the Consensus Standards Approval Committee (CSAC) Fall 2022 endorsement and maintenance cycle. Recommendations from the endorsement committee resulted in edits to the Getting Emotional and Religious Support to reflect cultural needs.

The Care Preferences, Hospice Team Communication, and Getting Hospice Care Training measures were on the 2023 Measures Under Consideration list (MUC2023-183,191 & 192) and evaluated by the Pre-Rulemaking Measure Review (PRMR) Post-Acute Care/Long-

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[29] The current version of the CAHPS Hospice Survey is available at: https://hospicecahpssurvey.org/en/survey-materials/. The proposed items for removal from this version of the survey are: Questions 32 through 34 (nursing home items), Question 30 (item about moving a family member), Question 10 (item regarding confusing or contradictory information), and Questions 17 through 20, 23, 28, and 29 (screening and evaluative items used to calculate the Getting Hospice Care Training measure).

[37] Ibid

[31] Ibid

Term Care (PAC/LTC) Committee. The Consensus-Based Entity (CBE) utilizes the Novel Hybrid Delphi and Nominal Group (NHDNG) multi-step process, which is an iterative consensus-building approach aimed at a minimum of 75 percent agreement among voting members, rather than a simple majority vote, and supports maximizing the time spent to build consensus by focusing discussion on measures where there is disagreement. The final result from the committee's vote can be: "Recommend", "Recommend with conditions", "Do not recommend" or "Consensus not reached". "Consensus not reached" signals continued disagreement amongst the committee despite being presented with perspectives from public comment, committee member feedback and discussion, and highlights the multi-faceted assessments of quality measures. The CBE did not reach consensus on the CAHPS Hospice Survey measures. More details regarding the CBE Pre-Rulemaking Measure Review (PRMR) voting procedures may be found in Chapter 4 of the Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review and Measure Set Review.[39]

Comment: Most commenters overwhelmingly supported the changes proposed for the CAHPS Hospice survey, including implementation of a web-mail mode, a shortened and simplified CAHPS Hospice Survey, extension of the field period, and the switch from Telephone Only to Mail Only as the reference mode for mode adjustments. However, many commenters asked that CMS delay the implementation of changes to the CAHPS Hospice Survey questionnaire and survey administration procedures.

Response: CMS appreciates the input and support of all stakeholders regarding the proposed changes. We had proposed that updates to the CAHPS Hospice Survey questionnaire and survey administration procedures, including availability of a new web-mail mode, be implemented with January 2025 decedents. The web-mail mode is optional; hospices do not need to select this mode in the first quarter in which it is available. Rather, hospices may choose

39 https://p4qm.org/sites/default/files/2023-09/Guidebook-of-Policies-and-Procedures-for-Pre-Rulemaking-Measure-Review-%28PRMR%29-and-Measure-Set-Review-%28MSR%29-Final_0.pdf

to pursue this mode for any future quarter, when they and their EMR vendors are ready to provide caregiver email addresses. The sample frame file layout provided in the Quality Assurance Guidelines currently available on the CAHPS Hospice Survey website (https://hospicecahpssurvey.org/en/quality-assurance-guidelines/) includes a variable for caregiver email addresses.

In response to commenters' concerns, CMS is finalizing implementation for April 2025 decedents, allowing hospices and vendors additional time to prepare. Survey vendors will be evaluated as to their readiness to administer the updated CAHPS Hospice Survey, as well as the web-mail mode. Training materials will be made available in early fall 2024; administration for April 2025 decedents is not slated to begin until summer 2025, allowing approximately 10 months for vendors to program and prepare materials. A draft of the updated survey instrument is already available for survey vendor review on the CAHPS Hospice Survey website (https://www.hospicecahpssurvey.org/globalassets/hospice-cahps4/survey-instruments/revised_cahps-hospice-survey_for-website.pdf).

CMS is finalizing the decision to implement the revised CAHPS Hospice Survey beginning with April 2025 decedents. Table 14 provides a comparison of the current and proposed CAHPS Hospice Survey measures.

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

Measure	Item(s) in Current Measure	Item(s) in Proposed Revised or New Measure
Getting Timely Care	"How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?"	"How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?"
	"While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?"	"When you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?"
Hospice Team Communication	"While your family member was in hospice care, how often did the hospice team keep you informed	"How often did the hospice team let you know when they would arrive to care for your family member?"

Measure	Item(s) in Current Measure	Item(s) in Proposed Revised or New Measure
	about when they would arrive to care for your family member?"	
	"While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?"	"How often did the hospice team explain things in a way that was easy to understand?"
	"While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?"	"How often did the hospice team keep you informed about your family member's condition?"
	"While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member's condition or care?"	N/A (removed from revised survey)
	"How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?"	"How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?"
	"While your family member was in hospice care, how often did the hospice team listen carefully to you?"	"While your family member was in hospice care, how often did the hospice team listen carefully to you?"
Treating Family Member with Respect	"While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?"	"How often did the hospice team treat your family member with dignity and respect?"
	"While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member?"	"How often did you feel that the hospice team really cared about your family member?"
Getting Help for Symptoms	"Did your family member get as much help with pain as he or she needed?"	"Did your family member get as much help with pain as they needed?"
	"How often did your family member get the help he or she needed for trouble breathing?"	"How often did your family member get the help they needed for trouble breathing?"
	"How often did your family member get the help he or she needed for trouble with constipation?"	"How often did your family member get the help needed for trouble with constipation?"
	"How often did your family member get the help he or she needed <u>from the hospice team</u> for feelings of anxiety or sadness?"	"How often did your family member get the help they needed <u>from the hospice team</u> for feelings of anxiety or sadness?"
Getting Emotional and	"Support for religious or spiritual beliefs includes talking, praying,	"Support for religious, spiritual, or cultural beliefs may include talking,

Measure	Item(s) in Current Measure	Item(s) in Proposed Revised or New Measure
Religious Support	quiet time, or other ways of meeting your religious or spiritual needs. While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?"	praying, quiet time, and respecting traditions. While your family member was in hospice care, how much support for your religious, spiritual, and cultural beliefs did you get from the hospice team?"
	"While your family member was in hospice care, how much emotional support did you get from the hospice team?"	"While your family member was in hospice care, how much emotional support did you get from the hospice team?"
	"In the weeks after your family member died, how much emotional support did you get from the hospice team?"	"In the weeks after your family member died, how much emotional support did you get from the hospice team?"
Getting Hospice Care Training	"Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with you or your family member?"	N/A (removed from revised survey)
	"Did the hospice team give you the training you needed about what side effects to watch for from pain medicine?"	N/A (removed from revised survey)
	"Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member?"	N/A (removed from revised survey)
	"Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing?"	N/A (removed from revised survey)
	"Did the hospice team give you the training you needed about what to do if your family member became restless or agitated?"	N/A (removed from revised survey)
	N/A (not on current survey)	"Hospice teams may teach you how to care for family members who need pain medicine, have trouble breathing, are restless or agitated, or have other care needs. Did the hospice team teach you how to care for your family member?"
Care preferences	N/A (not on current survey)	"Did the hospice team make an effort to listen to the things that mattered most to you or your family member?"
	N/A (not on current survey)	"Did the hospice team provide care that respected your family member's wishes?"

Measure	Item(s) in Current Measure	Item(s) in Proposed Revised or New Measure
Overall rating	"Please answer the following questions about your family member's care from the hospice named on the survey cover. Do not include care from other hospices in your answers. Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care?"	"Please answer the following questions about the hospice named on the survey cover. Do not include care from other hospices in your answers. Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care?"
Willingness to recommend	"Would you recommend this hospice to your friends and family?"	"Would you recommend this hospice to your friends and family?"

Comment: Some commenters requested changes in wording to the proposed new unscored item on unfair treatment because of race or ethnicity, noting that the proposed item uses a frequency response scale that may lead respondents to assume that unfair treatment occurred, and suggesting a broader question that addresses more potential sources of perceived unfair treatment.

Response: CMS thanks the commenters for these suggestions and may consider them in the future. The unfair treatment question included in the proposed updated CAHPS Hospice Survey questionnaire is the version that CMS tested in a 2021 experiment. Given the unique features of hospice and the caregiver respondents to the CAHPS Hospice Survey, CMS generally includes only those survey items that have been tested among hospice caregivers. The frequency response scale (never/sometimes/usually/always) used in the proposed question is parallel to the response scale to many questions on the CAHPS Hospice Survey. The "never" response option allows respondents to indicate that unfair treatment did not occur. In the 2021 experiment, 98.8 percent of respondents selected "never," indicating clearly that respondents did not assume unfair treatment occurred.

Comment: Some commenters requested updates to the questions on race and ethnicity to adhere to the Office of Management and Budget (OMB)'s recently published revised "Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity."

Response: CMS is currently evaluating the best option for implementing the revised standards for collecting race and ethnicity across all CAHPS surveys. When plans are finalized for implementing the revised standards, we will alert survey vendors and hospices.

Comment: Some commenters requested alignment across of CAHPS surveys in terms of language translations offered. One commenter asked that the web survey be available in multiple languages.

Response: The CAHPS Hospice Survey is available in a wide array of languages commonly spoken in the United States: English, Spanish, Traditional Chinese, Simplified Chinese, Russian, Portuguese, Vietnamese, Polish, and Korean. These translations are made available on the survey website (https://hospicecahpssurvey.org/en/survey-materials/); however, some translations have never been administered. We will continue to make additional translations available as additional needs are identified for translations.

Comment: A few commenters suggested additional edits to CAHPS Hospice Survey content, including minor edits to question wording, removal of an item regarding whether the respondent is male or female, and addition of a question about pain medication training.

Response: CMS appreciates commenters' suggestions regarding potential revisions to the questionnaire. The proposed updated CAHPS Hospice Survey questionnaire was drafted and tested in response to stakeholder feedback received over several years. Revisions, including item deletions and additions, were informed by submissions in response to calls for public comment in prior years' of federal rulemaking and by CMS's consensus-based entity, as well as a formal literacy review, a technical expert panel, cognitive interviews, and field testing. CMS is finalizing the updated CAHPS Hospice Survey questionnaire as proposed, to be implemented beginning with April 2025 decedents.

b. Impact to Public Reporting and Star Ratings

CAHPS Hospice Survey measure scores are calculated across eight rolling quarters and are published quarterly for all hospices with 30 or more completed surveys over the reporting

period. The Family Caregiver Survey Rating summary Star Rating is also calculated using eight rolling quarters and is publicly reported for all hospices with 75 or more completed surveys over the reporting period. Star Ratings are updated every other quarter. To determine what impact the changes to the survey measures would have on public reporting, CMS considered the nature of the measure change. As "Care Preferences" would be a new measure for the CAHPS Hospice Survey, we would have to wait to introduce public reporting until we have eight quarters of data. Although the revised "Getting Hospice Care Training" measure would be conceptually similar to the current "Getting Hospice Care Training" measure, we believe the change (one summary item instead of several items) is substantive and the revised measure should be treated as new for purposes of public reporting and Star Ratings. As such, we are waiting to publicly report the new version of "Getting Hospice Care Training" until we have eight quarters of data. We anticipate that the first Care Compare refresh in which publicly reported measures scores would be updated to include the new measures would be February 2028 (FY 2028), with scores calculated using data from Q2 2025 through Q1 2027. Because measure scores are calculated quarterly and Star Ratings are calculated every other quarter, these changes may be introduced in different quarters for measure scores and Star Ratings. In the interim period, measure scores would be made available to hospices confidentially in their Provider Preview reports once they met a threshold number of completed surveys.

We believe the finalized changes to the "Hospice Team Communication" measure (removing one item and slight wording changes) are non-substantive (that is, would not meaningfully change the measure) and that the measure could continue to be publicly reported and used in Star Ratings in the transition period between the current and new surveys. During the transition period, scores and Star Ratings would be calculated by combining scores from quarters using the current and new survey. As a result of the survey measure changes, the Family Caregiver Survey Rating summary Star Rating will be based on seven measures rather than the current eight measures during the interim period until a full eight quarters of data are

available for the "Getting Hospice Care Training" measure. The summary Star Rating would be based on nine measures once eight quarters of data are available for the new Care Preference and Getting Hospice Care Training measures.

c. Survey Administration Changes

CMS is also finalizing the decision to add a web-mail mode (email invitation to a web survey, with mail follow-up to non-responders); to add a pre-notification letter; and to extend the field period from 42 to 49 days, beginning with April 2025 decedents. The 2021 mode experiment found increases to response rates with these changes to survey administrative protocols. The web-mail mode would be an alternative to the current modes (mail-only, telephone-only, and mixed mode (mail with telephone follow-up)) that hospices could select. In the mode experiment, among those with no available email addresses, response rates to the mail-only and web-mail modes were similar (35.2 percent vs. 34.3 percent); however, among those with available email addresses, adjusted response rates were substantially and significantly different—36.7 percent for mail-only versus 49.6 percent for web-mail—suggesting a notable benefit of the web-mail mode for hospices with available email addresses for some caregivers.

In the mode experiment, we found that mailing a pre-notification letter one week prior to survey administration was associated with an increase in response rates of 2.4 percentage points. We currently require a prenotification letter for the Medicare Advantage and Prescription Drug Plan and the In-center Hemodialysis CAHPS initiatives, so there is precedent for this requirement for CAHPS surveys, and mailing the letter is well within the capabilities of all approved survey vendors.

Comment: Some commenters supported the addition of a prenotification letter as an evidence-based approach to increasing survey response rates, while other commenters noted concerns that a prenotification letter might increase costs to hospices. One commenter suggested that the prenotification letter be sent 14 days prior to survey administration.

Response: Mailed prenotification letters increase response to the first survey mailings, thereby reducing costs associated with sending a second mailing. CMS anticipates that any increases in cost will be small relative to the anticipated gains in survey response rates expected from the addition of a prenotification letter. In a 2021 experiment, CMS tested a prenotification letter 7 days prior to survey administration and determined that it was both acceptable to caregivers and workable on the current timeline for survey administration and data submission. CMS is finalizing the addition of a prenotification letter to the CAHPS Hospice Survey administration process beginning with April 2025 decedents.

Currently, the CAHPS Hospice Survey is fielded over 42 days; responses that come in after the 42-day window are not included in analysis and scoring. Extending the field period by one week (to 49 days) is feasible within the current national implementation data collection and submission timeline. Our decision to extend the field period to 49 days is estimated to result in an increased response rate of 2.5 percentage points in the mail-only mode, the predominant mode in which CAHPS Hospice Surveys are currently administered.

d. Case-mix and Mode Adjustments

Prior to public reporting, hospices' CAHPS Hospice Survey scores are adjusted for the effects of both mode of survey administration and case mix. Case mix refers to characteristics of the decedent and the caregiver that are not under control of the hospice that may affect reports of hospice experiences. Case-mix adjustment is performed within each quarter of data after data cleaning and mode adjustment. The current case-mix adjustment model includes the following variables: response percentile (the lag time between patient death and survey response), decedent's age, payer for hospice care, decedent's primary diagnosis, decedent's length of final episode of hospice care, caregiver's education, decedent's relationship to caregiver, caregiver's preferred language and language in which the survey was completed, and caregiver's age. CMS reviewed the variables included in the case-mix adjustment models currently in use for the CAHPS Hospice Survey to determine if any changes needed to be introduced along with the

revised survey and new mode. We found that no case-mix variables need to be added or removed.

With the introduction of a new mode of survey administration and survey items, CMS finalizes the decision to update the analytic adjustments that adjust responses for the effect of mode on survey responses. When we make mode adjustments, it is necessary to choose one mode as a reference mode. One can then interpret all adjusted responses from all modes as if they had been surveyed in the reference mode. Telephone-only is currently the reference mode for the CAHPS Hospice Survey. We are finalizing the decision to change the reference mode to mail-only. In the 2015 CAHPS Hospice Survey mode experiment, telephone-only respondents had consistently worse scores than mail-only respondents across measures. However, in the 2021 mode experiment, differences in scores between mail-only and telephone-only respondents were no longer in a consistent direction across measures. Given this, we are finalizing the decision to use mail-only as the reference mode beginning with April 2025 decedents as most surveys are currently completed in the mail-only mode.

Comment: Several commenters recommended that CMS add race and ethnicity to the case-mix adjustment model to reflect that hospices vary with regard to the proportion of their patients who are members of traditionally underserved communities.

Response: CMS is committed to scoring CAHPS Hospice Survey measures in a manner that allows for fair comparison between hospices, regardless of the populations they serve. Case-mix adjustment must account for factors outside of hospices' control that affect how caregivers respond to the CAHPS Hospice Survey. Given disagreement about whether and how to directly adjust for race and ethnicity, CMS instead adjusts CAHPS Hospice Survey measures for factors that are often associated with race and ethnicity. These include markers of socioeconomic status, such as caregiver education and payer for hospice care; preferred language, which has been shown to be associated with systematic differences in response; response percentile, which considers differential likelihood of response across hospices; and length of stay, a care pattern

which in some instances may be associated with differential care preferences across racial and ethnic groups.

Comment: A commenter suggested that length of stay should be considered in analysis of CAHPS Hospice Survey data, noting that very short lengths of stay can influence survey responses.

Response: CMS agrees that length of stay is an important consideration; for this reason, caregivers of decedents who received hospice care for less than 48 hours are not eligible for the CAHPS Hospice Survey, and length of stay is one of the variables used in case-mix adjustment of CAHPS Hospice Survey measure scores.

Comment: Several commenters requested that CMS conduct an analysis of the effects of updates to the CAHPS Hospice Survey questionnaire and administration procedures on the Hospice Special Focus Program (SFP) algorithm.

Response: CMS has specified four CAHPS Hospice Survey measures for use in calculating the SFP algorithm. These measures, Help for Pain and Symptoms, Getting Timely Help, Willingness to Recommend this Hospice, and Overall Rating of this Hospice, are not undergoing substantive changes in the proposed update of the CAHPS Hospice Survey questionnaire (that is, no survey items are being removed from, replaced, or added to these measures). CMS adjusts measure scores for mode of survey administration, so the introduction of a new mode should not impact measure scores. All changes to the survey instrument and administration procedures will be introduced at the same time for all hospices, so it should affect their scores equally; therefore, changes are not expected to differentially impact any hospices' performance on the SFP algorithm.

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

a. Statutory Penalty for Failure to Report

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form and

manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act was amended by the CAA, 2021 and the payment reduction for failing to meet hospice quality reporting requirements was increased from 2 percent to 4 percent beginning with FY 2024. During FYs 2014 through 2023, the Secretary reduced the market basket update by 2 percentage points for non-compliance. Beginning in FY 2024 and for each subsequent year, the Secretary will reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality measure data submission requirements for that FY. In the FY 2023 Hospice Wage Index final rule (87 FR 45669), we revised our regulations at § 418.306(b)(2) in accordance with this statutory change (86 FR 42605).

b. HOPE Data Collection

Hospices will be required to begin collecting and submitting HOPE data as of October 1, 2025. After this effective date, hospices will no longer be required to collect or submit the Hospice Item Set (HIS).

Hospices will begin the use of HOPE in October 2025 and submit HOPE assessments to the CMS data submission and processing system in the required format designated by CMS (as set out in subregulatory guidance. At the time of implementation (that is, October 2025), all HOPE records will need to be submitted as an XML file, which is also the required format for the HIS. The format is subject to change in future years as technological advancements occur and healthcare provider use of electronic records increases, as well as systems become more interoperable.

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

specifications are posted, during which we will respond to questions, comments, and suggestions. This process will ensure software developers and vendors are successful in developing their products to better support the successful implementation of HOPE for all parties. Hospice providers will need to use vendor software to submit HOPE records to CMS. As with HIS, facilities that fail to submit at least 90 percent of all required HOPE assessments to CMS will be subject to a 4 percent reduction. See "Submission of Data Requirements" section below for additional information.

c. Retirement of Hospice Abstraction Reporting Tool (HART)

In 2014, CMS made a free tool (Hospice Abstraction Reporting Tool, or HART) available which providers could use to collect HIS data. Over time we observed that only a small percentage of hospices utilized the tool. Therefore, in light of the limited utility the free tool provided, we will no longer provide a free tool for standardized data collection. Beginning October 1, 2025, hospices will need to select a private vendor to collect and submit HOPE data to CMS.

d. Compliance

HQRP Compliance requires understanding three timeframes for both HIS and CAHPS: The relevant Reporting Year; the payment FY; and the Reference Year.

(1) The 'Reporting Year" (HIS) or 'Data Collection Year" (CAHPS) is based on the calendar year (CY). It is the same CY for both HIS (or HOPE, once it is implemented) and CAHPS. If the CAHPS Data Collection year is CY 2025, then the HIS (or HOPE) reporting year is also CY 2025.

(2) In the "Payment FY", 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 before the Data Collection Year. The Reference Year applies to hospices submitting a size exemption from the CAHPS survey (there is no similar exemption for HIS or HOPE). For example, for the CY 2025

data collection year, the Reference Year is CY 2024. This means providers seeking a size exemption for CAHPS in CY 2025 will base it on their hospice size in CY 2024.

Submission requirements are codified at 42 CFR 418.312. Table 15 summarizes the three timeframes. It illustrates how the CY interacts with the FY payments, covering the CY 2023 through CY 2026 data collection periods and the corresponding APU application from FY 2025 through FY 2028. Please note that during the first reporting year that implements HOPE, APUs may be based on fewer than four quarters of data. CMS will provide additional subregulatory guidance regarding APUs for the HOPE implementation year.

TABLE 15: HQRP Reporting Requirements and Corresponding Annual Payment Updates

Reporting Year for HIS/HOPE 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 2023	FY 2025 APU	CY 2022
CY 2024	FY 2026 APU	CY 2023
CY 2025	FY 2027 APU	CY 2024
CY 2026	FY 2028 APU	CY 2025

As illustrated in Table 15 CY 2023 data submissions compliance impacts the FY 2025 APU. CY 2024 data submissions compliance impacts the FY 2026 APU. CY 2025 data submissions compliance impacts FY 2027 APU. This CY data submission impacting FY APU pattern follows for subsequent years.

e. Submission of Data Requirements

As finalized in the FY 2016 Hospice Wage Index final rule (80 FR 47142, 47192), hospices' compliance with HIS requirements beginning with the FY 2020 APU determination (that is, based on HIS- Admission and Discharge records submitted in CY 2018) are based on a timeliness threshold of 90 percent. This means CMS requires that hospices submit 90 percent of all required HIS records within 30 days of the event (that is, patient's admission or discharge). 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.

We will apply the same submission requirements for HOPE admission, discharge, and two HUV records. After HIS is phased out, hospices will continue to submit 90 percent of all required HOPE records to support the quality measures within 30 days of the event or completion date (patient's admission, discharge, and based on the patient's length of stay up to two HUV timepoints.

Hospice compliance with claims data requirements is based on administrative data collection. Since Medicare claims data are already collected from claims, hospices are considered 100 percent compliant with the submission of these data for the HQRP. There is no additional submission requirement for administrative data.

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

Table 16. HQRP Compliance Checklist illustrates the APU and timeliness threshold requirements.

TABLE 16: HQRP Compliance Checklist

Annual payment update	HIS/HOPE	CAHPS
FY 2025	Submit at least 90 percent of all HIS records within 30 days of the event date (for example patient's admission or discharge) for patient admissions/discharges occurring 1/1/23-12/31/23	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2023-12/31/2023
FY 2026	Submit at least 90 percent of all HIS records within 30 days of the event date (for example, patient's admission	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2024-12/31/2024

	or discharge) for patient admissions/discharges occurring 1/1/24-12/31/24	
FY 2027	Submit at least 90 percent of all HIS/HOPE records within 30 days of the event date (for example, patient's admission or discharge) for patient admissions/discharges occurring 1/1/25-12/31/25	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2025-12/31/2025
FY 2028	Submit at least 90 percent of all HIS/HOPE records within 30 days of the event or completion date (for example, patient's admission date, HUV completion date or discharge date) for patient admissions/discharges occurring 1/1/26-12/31/26	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2026-12/31/2026

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

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

IV. Collection of Information Requirements

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

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

We solicited public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. Hospice Outcomes & Patient Evaluation (HOPE)

As finalized in section III. of this final rule, we are using HOPE to collect QRP information through revisions to § 418.312(b). We are also finalizing the requirement of HOPE as a hospice patient-level item set to be used by all hospices to collect and submit standardized data on each patient admitted to hospice. The OMB control number will remain 0938-1153. HOPE will be used to support the standardized collection of the requisite data elements to calculate quality measures being utilized by the QRP. Hospices will be required to complete and submit an admission HOPE and a discharge HOPE collecting a range of status data (set out in the PRA accompanying this Rule, as well as the HOPE Guidance Manual finalized in this Rule)

for each patient, as well as a HOPE Update Visit assessment, when applicable, starting October 1, 2025, for FY 2027 APU determination.

CMS data indicates that approximately 5,640 hospices enroll approximately 2,763,850 patients in hospice annually.

According to the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2022 (see http://www.bls.gov/oes/current/oes_nat.htm), the median hourly wage for Registered Nurses is $39.05 and the mean hourly wage for Medical Secretaries is $18.51. With fringe benefits and overhead, the total per hour rate for Registered Nurses is $78.10, and the total per hour rate for Medical Secretaries is $37.02. The foregoing wage figures are outlined in Table 17:

TABLE 17: National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Median hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse	29-1141	$39.05	$39.05	$78.10
Medical Secretary	43-6013	$18.51	$18.51	$37.02

The annual time and cost burden for HOPE is calculated by determining the number of hours spent on each HOPE timepoint and using an average salary for nurses and medical secretaries to determine the average cost of the time spent on the assessment.

The total number of Medicare-participating hospices (5,640) and the total number of admissions per year (2,763,850) are gathered from claims data collected by CMS. Based on these claims data, we determined that there are approximately 490 admissions per hospice per year. We then use data from previous HIS item timings and HOPE beta testing to determine the average time to complete the three HOPE timepoints. The time-to-complete is then calculated for each HOPE timepoint for nurses (clerical staff are assumed to take 5 minutes per timepoint to upload data). HOPE Admission is estimated to take 27 minutes for a nurse to complete relative

to HIS, the new HOPE HUV is estimated to take 22 minutes for a nurse to complete, and 5 minutes for clerical staff to upload data and HOPE Discharge is estimated to take 0 minutes to complete. Together, these burden increases represent a 54-minute increase per assessment (22 + 27 + 5 = 54 minutes). We also note that, due to the addition of the HUV timepoints, hospices will submit an estimated 2,763,850 additional HOPE assessments (one HUV assessment per admission).

By multiplying the average time-to-complete with the number of records for a timepoint, we determine the average increase in burden hours spent for both nurses and clinical staff annually (Admission: 1,243,733 hours, HUV: 1,243,733 hours, Discharge: 0 hours). For additional information regarding the calculation of HOPE time and cost burdens, please refer to the HOPE Beta Testing Report found on the HOPE webpage at https://www.cms.gov/medicare/quality/hospice/hope and the PRA package associated with this rule found at https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing.

To calculate the cost burden, we multiply hospice staff wages by the amount of time those staff need to spend administering HOPE. We use the most recent hourly wage data for Registered Nurses ($39.05 per hour) and Medical Secretaries ($18.51 per hour) from the U.S. Bureau of Labor Statistics. These wages are doubled to account for fringe benefits ($78.10 for Registered Nurses, $37.02 for Medical Secretaries). Nurse and Medical Secretary wages are then calculated separately by multiplying time spent on timepoints with the number of HOPE records with the average wages (for example: 49 clinical minute increase on HOPE x 490 HOPE records per year / 60 minutes x $78.10 = $31,253.02 nursing wages spent per hospice per year). The calculations for each of these hospice staff disciplines are added together to determine the total cost burden increase per hospice.

Based on these calculations, we estimate that our proposal would therefore result in an incremental increase of 2,487,466-hour annual burden (1,243,733 hours for HOPE Admissions,

1,243,733 hours for HOPE Update Visits, and 0 hours for HOPE Discharges) at a cost of $184,792,739. The total cost burden per hospice ($32,764.67) is calculated by adding the total clinical cost ($31,253.02,) with the total clerical staff cost burden (5 minutes x 490 HOPE Records per each hospice per year / 60 minutes per hour x $37.02 per hour = $1,511.65). This leads to a cost burden of $184, 792,739 across all hospices ($32,764.67 per hospice X 5,640 hospices). Table 18 provides the summary of changes in burden relative to the new HOPE Admission, Update Visit and Discharge timepoints. We received public comments that expressed concerns about the anticipated incremental burden the new measures will add to hospices. This increase in incremental burden is explained further in the Regulatory Impact Analysis (RIA) section of this Rule, and is also discussed in detail in the Information Collection Request and PRA accompanying this Rule.

TABLE 18: Summary of Changes in Burden

Regulation Section(s)	Number of Respondents	Number of Responses (per year)	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($)	Total Cost ($)
HOPE Admission Timepoint	5,640	2,763,850	Clinician: 0.45 Clerical: 0	Clinician: 1,243,733 Clerical: 0	Clinician at $78.10 per hour; Clerical staff at $37.02 per hour	$97,135,547
HUV Timepoint	5,640	2,763,850	Clinician: 0.37 Clerical: 0.083	Clinician: 1,013,411 Clerical: 230,321	Clinician at $78.10 per hour; Clerical staff at $37.02 per hour	$87,657,192
HOPE Discharge Timepoint	5,640	2,763,850	Clinician: 0 Clerical: 0	Clinician: 0 Clerical: 0	Clinician at $78.10 per hour; Clerical staff at $37.02 per hour	$0

TOTAL IMPACT	**5,640**	**2,763,850**	**Clinician: 0.82** **Clerical: 0.083**	**Clinician: 2,257,144** **Clerical: 230,321**	**Clinician at $78.10 per hour; Clerical staff at $37.02 per hour**	**$184,792,739**

Numbers may not add due to rounding.

B. Amendment of HQRP Data Completeness Thresholds

The amended HQRP data completeness thresholds reflect the same thresholds which have been applied to the HQRP since the FY 2018 Hospice final rule as they relate to HIS. As such, this requirement does not impose any additional completeness or timeliness burden on hospices for the forthcoming fiscal year.

V. Regulatory Impact Analysis

A. Statement of Need

1. Hospice Payment

This final rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the Hospice Wage Index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This final rule updates the payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2025 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

2. Quality Reporting Program

This final rule updates the requirements for HQRP to use a new standardized patient assessment tool, HOPE, which is more comprehensive than the previous HIS and includes new data elements and a new time point. These changes will allow HQRP to reflect a more consistent and holistic view of each patient's hospice election. This new reporting instrument will collect data that supports current and newly finalized quality measures included in this rule and potential

future quality measures. The new HOPE data elements are not only collected by chart abstraction but in real-time to adequately assess patients based on the hospice's interactions with the patient and family/caregiver, accommodate patients with varying clinical needs, and provide additional information to contribute to the patient's care plan throughout the hospice stay (not just at admission and discharge).

B. Overall Impacts

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 14094 on Modernizing Regulatory Review (April 6, 2023), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96 354), section 1102(b) of the 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 (CRA) (5 U.S.C. 804(2)).

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

would meaningfully further the President's priorities or the principles set forth in this Executive Order.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant section 3(f)(1). Based on our estimates, OMB'S Office of Information and Regulatory Affairs has determined this rulemaking is significant under section 3(f)(1) of E.O. 12866. Accordingly, we have prepared a regulatory impact analysis presents the costs and benefits of the rulemaking to the best of our ability. Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has also determined that this rule meets the criteria set forth in 5 U.S.C. 804(2).

1. Hospice Payment

The aggregate impact of the payment provisions in this final rule will result in an estimated increase of $790 million in payments to hospices, resulting from the finalized hospice payment update percentage of 2.9 percent for FY 2025. The impact analysis of this rule represents the projected effects of the changes in hospice payments from FY 2024 to FY 2025. Using the most recent complete data available at the time of rulemaking, in this case FY 2023 hospice claims data as of May 09, 2024, we simulate total payments using the FY 2024 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, and old OMB delineations with the 5-percent cap on wage index decreases) and FY 2024 payment rates and compare it to our simulation of total payments using FY 2023 utilization claims data, the final FY 2025 Hospice Wage Index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the revised OMB delineations with a 5-percent cap on wage index decreases) and FY 2024 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2024 wage index and payment rates for each level of care by the final FY 2025 wage index and FY 2024 payment rates, we obtain a wage index standardization factor for each level of care. We apply the wage index standardization factors so

that the aggregate simulated payments do not increase or decrease due to changes in the wage index.

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

2. Hospice Quality Reporting Program

As finalized in section III of this final rule, we are requiring implementation of a hospice patient-level item set to be used by all hospices to collect and submit standardized data on each patient admitted to hospice. Based on the cost estimates provided in the Collection of Information section, we are finalizing an annual cost burden of $184,729,739 across all hospices ($32,764.67 per hospice X 5,640 hospices) starting in FY 2026.

TABLE 19: Summary of Burden Hours and Costs*

Regulation Section(s)	Number of Respondents	Number of Responses (per year)	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($)	Total Cost ($)
HOPE Admission Timepoint	5,640	2,763,850	Clinician: 0.45 Clerical: 0	Clinician: 1,243,733 Clerical: 0	Clinician at $78.10 per hour; Clerical staff at $37.02 per hour	$97,135,547
HUV Timepoints	5,640	2,763,850	Clinician: 0.37 Clerical: 0.083	Clinician: 1,013,411 Clerical: 230,321	Clinician at $78.10 per hour; Clerical staff at $37.02 per hour	$87,657,192
HOPE Discharge Timepoint	5,640	2,763,850	Clinician: 0 Clerical: 0	Clinician: 0 Clerical: 0	Clinician at $78.10 per hour; Clerical staff at $37.02 per hour	$0

Regulation Section(s)	Number of Respondents	Number of Responses (per year)	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($)	Total Cost ($)
TOTAL IMPACT	**5,640**	**2,763,850**	**Clinician: 0.82** **Clerical: 0.083**	**Clinician: 2,257,144** **Clerical: 230,321**	**Clinician at $78.10 per hour; Clerical staff at $37.02 per hour**	**$184,792,739**

Numbers may not add due to rounding.

Our final analysis will therefore result in a 2,487,466 -hour annual burden (1,243,733 hours for HOPE Admissions, 1,243,733 hours for HOPE Update Visits, and 0 hours for HOPE Discharges). The total cost burden per hospice ($32,764.67) is calculated by adding the total nursing cost with the total clerical staff cost burden. This leads to a cost burden of $184, 792,739 across all hospices ($32,764.67 per hospice X 5,640 hospices). This burden is also discussed in detail below and as part of an accompanying PRA submission.

C. Detailed Economic Analysis

1. Hospice Payment Update for FY 2025

The FY 2025 hospice payment impacts appear in Table 20. 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, and 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 2025 updated wage index data and moving from the old OMB delineations to the new revised OMB delineations with a 5-percent cap on wage index decreases. The aggregate impact of the changes in column three is zero percent, due to the hospice wage index standardization factors. However, there are distributional effects of using the FY 2025 hospice wage index. The fourth column shows the effect of the hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act and is consistent for all providers.

The hospice payment update percentage of 2.9 percent is based on the 3.4 percent inpatient hospital market basket percentage increase reduced by a final 0.5 percentage point productivity adjustment. The fifth column shows the total effect of the updated wage data and the hospice payment update percentage on FY 2025 hospice payments. As illustrated in Table 20, the combined effects vary by specific types of providers and by location. We note that simulated payments are based on utilization in FY 2023 as seen on Medicare hospice claims (accessed from the CCW on May 09, 2024) 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 20, the combined effects vary by specific types of providers and by location.

TABLE 20: Impact to Hospices for FY 2025

Hospice Subgroup	Hospices	FY 2025 Updated Wage Data and Revised OMB Delineations	FY 2025 Hospice Payment Update (%)	Overall Total Impact for FY 2025
All Hospices	6,073	0.0%	2.9%	2.9%
Hospice Type and Control				
Freestanding/Non-Profit	551	0.2%	2.9%	3.1%
Freestanding/For-Profit	4,028	0.0%	2.9%	2.9%
Freestanding/Government	37	-0.7%	2.9%	2.2%
Freestanding/Other	362	-0.2%	2.9%	2.7%
Facility/HHA Based/Non-Profit	317	-0.7%	2.9%	2.2%
Facility/HHA Based/For-Profit	190	0.0%	2.9%	2.9%
Facility/HHA Based/Government	71	0.2%	2.9%	3.1%
Facility/HHA Based/Other	84	-0.9%	2.9%	2.0%
Subtotal: Freestanding Facility Type	4,978	0.1%	2.9%	3.0%
Subtotal: Facility/HHA Based Facility Type	662	-0.5%	2.9%	2.4%
Subtotal: Non-Profit	868	0.0%	2.9%	2.9%
Subtotal: For Profit	4,221	0.0%	2.9%	2.9%
Subtotal: Government	108	-0.2%	2.9%	2.7%
Subtotal: Other	446	-0.3%	2.9%	2.6%
Hospice Type and Control: Rural				

Hospice Subgroup	Hospices	FY 2025 Updated Wage Data and Revised OMB Delineations	FY 2025 Hospice Payment Update (%)	Overall Total Impact for FY 2025
Freestanding/Non-Profit	124	0.0%	2.9%	2.9%
Freestanding/For-Profit	351	0.3%	2.9%	3.2%
Freestanding/Government	22	-0.2%	2.9%	2.7%
Freestanding/Other	55	0.4%	2.9%	3.3%
Facility/HHA Based/Non-Profit	118	0.2%	2.9%	3.1%
Facility/HHA Based/For-Profit	52	0.5%	2.9%	3.4%
Facility/HHA Based/Government	55	0.3%	2.9%	3.2%
Facility/HHA Based/Other	46	0.0%	2.9%	2.9%
Hospice Type and Control: Urban				
Freestanding/Non-Profit	427	0.2%	2.9%	3.1%
Freestanding/For-Profit	3,677	0.0%	2.9%	2.9%
Freestanding/Government	15	-0.9%	2.9%	2.0%
Freestanding/Other	307	-0.2%	2.9%	2.7%
Facility/HHA Based/Non-Profit	199	-0.9%	2.9%	2.0%
Facility/HHA Based/For-Profit	138	0.0%	2.9%	2.9%
Facility/HHA Based/Government	16	0.2%	2.9%	3.1%
Facility/HHA Based/Other	38	-1.1%	2.9%	1.8%
Hospice Location: Urban or Rural				
Rural	826	0.3%	2.9%	3.2%
Urban	5,247	0.0%	2.9%	2.9%
Hospice Location: Region of the Country (Census Division)				
New England	148	-1.6%	2.9%	1.3%
Middle Atlantic	280	-0.7%	2.9%	2.2%
South Atlantic	607	1.0%	2.9%	3.9%
East North Central	606	0.1%	2.9%	3.0%
East South Central	252	0.9%	2.9%	3.8%
West North Central	417	-0.1%	2.9%	2.8%
West South Central	1,154	0.5%	2.9%	3.4%
Mountain	610	1.5%	2.9%	4.4%
Pacific	1,951	-1.9%	2.9%	1.0%
Outlying	48	-1.6%	2.9%	1.3%
Hospice Size				
0 - 3,499 RHC Days (Small)	1,494	-1.1%	2.9%	1.8%
3,500-19,999 RHC Days (Medium)	2,738	-0.3%	2.9%	2.6%
20,000+ RHC Days (Large)	1,841	0.1%	2.9%	3.0%

Source: FY 2023 hospice claims data from CCW accessed on May 9, 2024.
Note: The overall total impact reflects the addition of the individual impacts, which includes the wage index impact, new OMB delineations, as well as the 2.9% hospice payment update percentage.

Due to missing Provider of Services file information (from which hospice characteristics are obtained), some subcategories in the impact tables have fewer agencies represented than the overall total (of 6,073). Subtypes involving ownership only add up to 5,643 while subtypes involving facility type only add up to 5,640.
Region Key:
New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central=Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas
Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific= Alaska, California, Hawaii, Oregon, Washington
Outlying=Guam, Puerto Rico, Virgin Islands

2. Impacts for the Hospice Quality Reporting Program for FY 2025

The HQRP requires the active collection under OMB control number #0938-1153 (CMS 10390; expiration 01/31/2026) of the Hospice Items Set (HIS) and CAHPS® Hospice Survey (OMB control number 0938-1257 (CMS–10537; 07/31/2026). Failure to submit data required under section 1814(i)(5) of the Act with respect to a CY will result in the reduction of the annual market basket percentage increase otherwise applicable to a hospice for that calendar year.

Once adopted, the federal government will incur costs related to the transition from HIS to HOPE. These costs will include provider training, preparation of HOPE manuals and materials, receipt and storage of data, data analysis, and upkeep of data submission software. There are costs associated with the maintenance and upkeep of a CMS-sponsored web-based program that hospice providers would use to submit their HOPE data. In addition, the Federal government will also incur costs for help-desk support that must be provided to assist hospices with the data submission process. There will also be costs associated with the transmission, analysis, processing, and storage of the hospice data by CMS contractors.

Also, pursuant to section 1814(i)(5)(A)(i) of the Act, hospices that do not submit the required QRP data would receive a 4 percentage point reduction of the annual market basket

increase. The federal government will incur additional costs associated with aggregation and analysis of the data necessary to determine provider compliance with the reporting requirements for any given fiscal year.

The total annual cost to the federal government for the implementation and ongoing management of HOPE data is estimated to be $1,583,500. As this number is the same as the current final costs to the federal government associated with HIS, HOPE implementation and ongoing maintenance would not incur additional annual costs.

The costs to hospice providers associated with HOPE are calculated as follows:

PART 1. Time Burden

Estimated Number of Admissions and Records per Hospice

	Admissions/Records	Hospices	Per Year		Per 3 Years
Admissions	2,763,850	5,640	490		1,470
Total HOPE Records (Admission, HUV, Discharge)	8,291,550	5,640	1,470		4,410

Estimated Number of Admissions and Records for all Hospices

	Admissions/Records	Hospices		Per 3 Years
Admissions	2,763,850	5,640		8,291,550
Total HOPE Records (Admission, HUV, Discharge)	8,291,550	5,640		24,874,650

Estimated HOPE Burden Hours per Year, by Time Point

Burden Hours per year (HOPE Admission)			
Discipline	**Records**	**Hours**	**Total time**
Clinical	2,763,850	0.45 (27 minutes)	1,243,733 hours
Clerical	2,763,850	0 (0 minutes)	0 hours
Total (HOPE Admission)			**1,243,733 hours**
Burden Hours per year (HOPE HUV)			
Discipline	**Records**	**Hours**	**Total time**
Clinical	2,763,850	0.37 (22 minutes)	1,013,411 hours
Clerical	2,763,850	0.083 (5 minutes)	230,321 hours
Total (HOPE HUV)			**1,243,733 hours**

Burden Hours per year (HOPE Discharge)			
Discipline	**Records**	**Hours**	**Total time**
Clinical	2,763,850	0 (0 minutes)	0 hours
Clerical	2,763,850	0 (0 minutes)	0 hours
Total (HOPE Discharge)			**0 hours**

PART 2. Cost/Wage Calculation

Note that this analysis of HOPE costs presents rounded inputs for each calculation and based on the incremental increase of burden from the HIS timepoints. The actual calculations were performed using unrounded inputs, so the outputs of each equation shown may vary slightly from what would be expected from the rounded inputs.

Time for All Hospices

Discipline	**Hours**	**Records**	**Total time**
Nursing	0.82 (49 minutes)	2,763,850	2,257,144 hours
Administrative Assistant	0.08 (5 minutes)	2,763,850	230,321 hours
Total			**2,487,465 hours**

TABLE 21: Aggregate Cost Calculations

Aggregate Annual Cost Per Hospice			
Discipline	**Hours**	**Wages**	**Total cost**
Clinical	400.17	$78.10	$31,253.02
Clerical	40.83	$37.02	$1,511.65
Total			**$32,764.67**
Aggregate Annual Cost For All Hospice Providers			
Discipline	**Hours**	**Wages**	**Total cost**
Clinical	2,257,144	$78.10	$176,282,998
Clerical	230,321	$37.02	$8,526,477
Total			**$184,792,739**
Aggregate 3-Year Cost Per Hospice Provider			
Discipline	**Hours**	**Wages**	**Total cost**
Clinical	1205.4	$78.10	$93,760
Clerical	117.6	$37.02	$4,534
Total			$98,294
Aggregate 3-Year Cost For All Hospice Providers.			
Discipline	**Hours**	**Wages**	**Total cost**

Clinical	6,711,432	$78.10	$528,848,994
Clerical	690,963	$37.02	$25,579,431
Total			**$554,428,425**

Additional details regarding these costs and calculations are available in the FY 2025 PRA package.

In addition, the transition from HIS to HOPE may result in other clinical and administrative time to hospice providers. However, as illustrated above the incremental burden assumes that hospices are providing in-person visits as part of their regular update to the plan of care, and anticipated patient needs for pain and symptom management (42 CFR 418.54 and 418.56) beyond meeting the requirement for quality reporting data collection (42 CFR 418.312). This assumption is supported by HOPE testing and hospice provider and TEP feedback throughout the HOPE development process. CMS acknowledges that we have not in this rule quantified the costs associated beyond the time necessary to gather and submit assessment instrument data. However, based on public comments, we will monitor the burden of in-person follow-up visits after HOPE implementation and its implications to quality of care, as noted above.

3. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review this rule, we assume that the total number of unique commenters on this year's proposed rule will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this final rule. It is possible that not all commenters reviewed this year's proposed 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 final rule.

We received no comments on the approach to estimating the number of entities that will review this final rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

Using the occupational wage information from the BLS for medical and health service managers (Code 11-9111); we estimate that the cost of reviewing this rule is $129.28 per hour, including overhead and fringe benefits (https://www.bls.gov/oes/current/ oes_nat.htm). This final rule consists of approximately 53,138 words. Assuming an average reading speed we estimate that it would take approximately 1.76 hour for staff to review half of this final rule. For each hospice that reviews the rule, the estimated cost is $227.53 (1.76 hours × $129.28). Therefore, we estimate that the total cost of reviewing this regulation is $25,028 ($227.53 × 110 reviewers).

D. Alternatives Considered

1. Hospice Payment

For the FY 2025 Hospice Wage Index and Rate Update final rule, we considered alternatives to the proposals articulated in section III.A of this final rule. We considered not proposing to adopt the OMB delineations listed in OMB Bulletin 23-01; however, we have historically adopted the latest OMB delineations in subsequent rulemaking after a new OMB Bulletin is released.

Since the hospice payment update percentage is determined based on statutory requirements, we did not consider alternatives to updating the hospice payment rates by the hospice payment update percentage. The final 2.9 percent hospice payment update percentage for FY 2025 is based on a 3.4 percent inpatient hospital market basket percentage increase for FY 2025, reduced by a 0.5 percentage point productivity adjustment. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage

increase for that FY. Section 3401(g) of the Affordable Care Act also mandates that, starting with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. For FY 2025, since the hospice payment update percentage is determined based on statutory requirements at section 1814(i)(1)(C) of the Act, we did not consider alternatives for the hospice payment update percentage.

2. Hospice Quality Reporting Program

CMS considered proposing the HOPE instrument with more items, including data collection about the treatment and activities provided by multiple disciplines (such as medical social workers (MSW) and chaplains). However, CMS ultimately omitted those additional items, and is only finalizing HOPE with items deemed relevant to current and planned quality measurement and public reporting activities.

CMS considered proposing that hospices only need to collect HOPE data during one HUV rather than two. CMS considered changing the data submission requirement from thirty (30) days to fifteen (15) days. However, CMS determined that such a change would provide minimal benefit at this time while also being disruptive to hospice providers and this was not proposed or finalized.

E. Accounting Statement and Table

As required by OMB Circular A-4 (available at https://www.whitehouse.gov/wp-content/uploads/2023/11/CircularA-4.pdf), in Table 22, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 22 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this rule. This estimate is based on the data for 6,044 hospices in our impact analysis file, which was constructed using FY 2023 claims (accessed from the CCW on May 09, 2024). All expenditures are classified as transfers to

hospices. Also, Table 22 also provides the impact costs associated with the Hospice Quality Reporting Program starting FY 2026.

TABLE 22: Accounting Statement
Classification of Estimated Transfers and Costs

Hospice Payment Update	**FY 2024 to FY 2025**
Category	**Transfers**
Annualized Monetized Transfers	$790 million*
From Whom to Whom?	Federal Government to Medicare Hospices
Hospice Quality Reporting Program	**FY 2026 to FY 2029**
Category	**Costs**
Annualized Costs	$185 million (2% Discount Rate)

*The increase of $790 million in transfer payments is a result of the 2.9 percent hospice payment update compared to payments in FY 2024.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small jurisdictions. We consider all hospices as small entities as that term is used in the RFA. The North American Industry Classification System (NAICS) was adopted in 1997 and is the current standard used by the Federal statistical agencies related to the U.S. business economy. There is no NAICS code specific to hospice services. Therefore, we utilized the NAICS U.S. industry title "Home Health Care Services" and corresponding NAICS code 621610 in determining impacts for small entities. The NAICS code 621610 has a size standard of $19 million.[40] Table 23 shows the number of firms, revenue, and estimated impact per home health care service category.

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

TABLE 23: NUMBER OF FIRMS, REVENUE, AND ESTIMATED IMPACT OF HOME HEALTH CARE SERVICES BY NAICS CODE 621610

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

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

The Department of Health and Human Services' practice in interpreting the RFA is to consider effects economically "significant" only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The majority of hospice visits are Medicare paid visits, and therefore the majority of hospice's revenue consists of Medicare payments. Based on our analysis, we conclude that the policies finalized in this rule would result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of hospices. Therefore, the Secretary has certified that this hospice final rule would have significant economic impact on a substantial number of small entities. We estimate that the net impact of the policies in this rule is 2.9 percent or approximately $790 million in increased revenue to hospices in FY 2025. The 2.9 percent increase in expenditures when comparing FY 2024 payments to estimated FY 2025 payments is reflected in the last column of the first row in Table 20 and is driven solely by the impact of the hospice payment update percentage reflected in the fourth column of the impact table. In addition, small hospices will experience a lower estimated increase (1.8 percent), compared to large hospices (3.0 percent) due to the final updated wage index. Further detail is presented in Table 20 by hospice type and location.

We estimate that the new impact of the HQRP data collection requirements would be $32,764.81 per hospice. While small hospices will incur the same data collection impact as all

other hospices, we recognize that the impact value is likely to represent a larger percentage of small provider costs. HOPE already minimizes the burden that Information Collection Requests (ICRs) place on the provider. The type of quality data specified for participation in the HQRP is already currently collected by hospices as part of their patient care processes.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a MSA and has fewer than 100 beds. This rule will only affect hospices. Therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals (see Table 19).

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2024, that threshold is approximately $183 million. This rule will have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $183 million or more in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this rule under these criteria of Executive

Order 13132 and have determined that it will not impose substantial direct costs on State or local governments.

I. Conclusion

The aggregate payments to hospices in FY 2025 will increase by $790 million as a result of the hospice payment update, compared to payments in FY 2024. We estimate that in FY 2025, hospices in urban areas would experience, on average, a 2.9 percent increase in estimated payments compared to FY 2024; while hospices in rural areas would experience, on average, a 3.2 percent increase in estimated payments compared to FY 2024. Hospices providing services in the Mountain region would experience the largest estimated increases in payments of 4.4 percent. Hospices serving patients in the Pacific region will experience, on average, the lowest estimated increase of 1.0 percent in FY 2025 payments.

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

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 23, 2024.

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 amends 42 CFR chapter IV, part 418 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 418.22 is amended by revising paragraph (c)(1)(i) to read as follows:

§ 418.22 Certification of terminal illness.

* * * * *

(c) * * *

(1) * * *

(i) The medical director of the hospice, the physician designee (as defined in § 418.3), or the physician member of the hospice interdisciplinary group; and

* * * * *

3. Section 418.24 is amended by--

a. Revising paragraphs (a) and (b)(3);

b. Redesignating paragraphs (e) through (h) as paragraphs (f) through (i), respectively; and

c. Adding paragraph (e).

The revisions and addition read as follows:

§ 418.24 Election of hospice care.

(a) *Election statement.* An individual who meets the eligibility requirement of § 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative (as defined in § 418.3) may file the election statement.

(b) * * *

(3) Acknowledgement that the individual has been provided information on the hospice's coverage responsibility and that certain Medicare services, as set forth in paragraph (g) of this section, are waived by the election. For Hospice elections beginning on or after October 1, 2020, this would include providing the individual with information indicating that services unrelated to the terminal illness and related conditions are exceptional and unusual and hospice should be providing virtually all care needed by the individual who has elected hospice.

* * * * *

(e) *Notice of election.* The hospice chosen by the eligible individual (or his or her representative) must file the Notice of Election (NOE) with its Medicare contractor within 5 calendar days after the effective date of the election statement.

(1) *Consequences of failure to submit a timely notice of election.* When a hospice does not file the required Notice of Election for its Medicare patients within 5 calendar days after the effective date of election, Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the notice of election. These days are a provider liability, and the provider may not bill the beneficiary for them.

(2) *Exception to the consequences for filing the NOE late.* CMS may waive the consequences of failure to submit a timely-filed NOE specified in paragraph (e)(1) of this section. CMS will determine if a circumstance encountered by a hospice is exceptional and qualifies for waiver of the consequence specified in paragraph (e)(1) of this section. A hospice must fully document and furnish any requested documentation to CMS for a determination of exception. An exceptional circumstance may be due to, but is not limited to, the following:

(i) Fires, floods, earthquakes, or similar unusual events that inflict extensive damage to the hospice's ability to operate.

(ii) A CMS or Medicare contractor systems issue that is beyond the control of the hospice.

(iii) A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.

(iv) Other situations determined by CMS to be beyond the control of the hospice.

4. Section 418.25 is amended by revising paragraphs (a) and (b) introductory text to read as follows:

§ 418.25 Admission to hospice care.

(a) The hospice admits a patient only on the recommendation of the medical director (or the physician designee, as defined in § 418.3) in consultation with, or with input from, the patient's attending physician (if any).

(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director (or the physician designee, as defined in § 418.3) must consider at least the following information:

* * * * *

5. Section 418.102 is amended by revising the introductory paragraph, paragraph (b) introductory text, and paragraph (c) to read as follows:

§ 418.102 Condition of participation: Medical director.

The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee or is under contract with the hospice. When the medical director is not available, a physician designee as defined at § 418.3 assumes the same responsibilities and obligations as the medical director.

* * * * *

(b) *Standard: Initial certification of terminal illness*. The medical director (or physician designee, as defined in § 418.3, if the medical director is unavailable) or physician member of the IDG reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness

runs its normal course. The physician must consider the following when making this determination:

* * * * *

(c) *Standard: Recertification of the terminal illness.* Before each recertification period for each patient, as described in § 418.21(a), the medical director (or physician designee, as defined in § 418.3, if the medical director is unavailable) or physician member of the IDG must review the patient's clinical information.

* * * * *

6. Section 418.114 is amended by revising paragraph (b)(9) to read as follows:

§ 418.114 Condition of participation: Personnel qualifications.

* * * * *

(b) * * *

(9) Marriage and family therapist as defined at § 410.53.

* * * * *

§ 418.309 [Amended]

7. Section 418.309 is amended in paragraphs (a)(1) and (2) by removing ‘‘2032’’ and adding in its place ‘‘2033’’.

8. Section 418.312 is amended by revising paragraph (b)(1) to read as follows:

§ 418.312 Data submission requirements under the hospice quality reporting program

* * * * *

(b) * * *

(1) Hospices are required to complete and submit a standardized set of items for each patient to capture patient-level data, regardless of payer or patient age. The standardized set of items must be completed no less frequently than at admission, the hospice update visit (HUV), and discharge, as directed in the associated guidance manual and required by the Hospice Quality Reporting Program. Definitions for changes in patient condition that warrant updated

assessment, as well as the data elements to be completed for each applicable change in patient condition, are to be provided in sub-regulatory guidance for the current standardized hospice instrument.

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Xavier Becerra,

Secretary,

Department of Health and Human Services.

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