DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1810–P]

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: Proposed rule.

SUMMARY: This proposed rule would update the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year (FY) 2025. This rule proposes changes to the Hospice Quality Reporting Program. This rule also proposes to adopt the most recent Office of Management and Budget statistical area delineations, which would change the hospice wage index. This rule proposes to clarify current policy related to the ''election statement'' and the ''notice of election'', as well as to add clarifying language regarding hospice certification. Finally, this rulemaking solicits comments regarding potential implementation of a separate payment mechanism to account for high intensity palliative care services.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than May 28, 2024.

ADDRESSES: In commenting, refer to file code CMS–1810–P.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1810–P, P.O. Box 8010, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1810–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT:

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

For questions regarding the CAHPS® Hospice Survey, contact 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:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this proposed rule may be found at *https://www.regulations.gov/*.

I. Executive Summary

A. Purpose

This proposed rule would update 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 proposes to adopt the most recent Office of Management and Budget (OMB) statistical area delineations based on data collected during the 2020 Decennial Census, which would result in changes to the hospice wage index. In addition, this rule proposes reorganization of the regulations to clarify current policy related to the ''election statement'' and the ''notice of election (NOE),'' as well as to add clarifying language regarding who can certify terminal illness. This rulemaking solicits comments on a potential policy to account for the increased hospice costs of providing high intensity palliative care services. In past rules, we have presented data regarding important hospice utilization trends. This year, and in subsequent years, the monitoring section will be removed from the rulemaking and placed on the CMS hospice center web page, which can be found at *https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice*.

This rule also proposes that Hospice Quality Reporting Program (HQRP) measures be collected through a new collection instrument, the Hospice Outcomes and Patient Evaluation (HOPE); this rule also proposes two HOPE-based measures and lays out the planned trajectory for further development of this instrument; requests information regarding potential social determinants of health (SDOH) elements and provides updates on Health Equity, future quality measures (QMs), and public reporting requirements. Finally, this rule also proposes 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 proposed rule proposes updates to the hospice wage index and makes the application of the updated wage data budget neutral for all four levels of hospice care.

Section III.A.2 of this proposed rule proposes to adopt 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 proposed rule includes the proposed FY 2025 hospice payment update percentage of 2.6 percent.

Section III.A.4 of this proposed rule proposes updates to the hospice payment rates.

Section III.A.5 of this proposed rule includes the proposed update to the hospice cap amount for FY 2025 by the hospice payment update percentage of 2.6 percent.

In section III.B of this proposed rule, we propose clarifying regulation text changes, 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 Conditions of Participation (CoPs) regarding who may certify terminal illness and determine admission to hospice care.

In section III.C of this proposed rule, we include a Request for Information (RFI) 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 rule proposed rule, we propose HOPE-based process measures; the HOPE instrument; discuss updates to potential future quality measures; and propose changes to the CAHPS® Hospice Survey.

C. Summary of Impacts

The overall economic impact of this proposed rule is estimated to be $705 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 his or her life expectancy is 6 months or less if the illness runs its normal course. The regulations at § 418.22(b)(2) require that clinical information and other documentation that support the medical prognosis accompany the certification and be filed in the medical record with it. The regulations at § 418.22(b)(3) require that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

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

If, in the judgment of the hospice interdisciplinary group, which includes the hospice physician, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to their home and continue to receive routine home care (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 proposed rule must comply with applicable civil rights laws, including section 1557 of the Affordable Care Act, section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, which require covered programs to take appropriate steps to ensure effective communication with individuals with disabilities and companions with disabilities, including the provisions of auxiliary aids and services when necessary for effective communication.[1] Further information may be found at: *https://www.hhs.gov/civil-rights/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 implementing regulation requires covered entities to take reasonable steps to provide meaningful access to LEP individuals in federally funded health programs and activities (45 CFR 92.101(a)). Meaningful access may require the provision of interpreter services and translated materials (45 CFR 92.101(a)(2)).

B. Services Covered by the Medicare Hospice Benefit

Coverage under the Medicare hospice benefit requires that hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. Section 1861(dd)(1) of the Act establishes the services that are to be rendered by a Medicare-certified hospice program. These covered services include: nursing care; physical therapy; occupational therapy; speech-

[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 FR 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.*

language pathology therapy; medical social services; home health aide services (called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologicals); medical appliances; counseling services (including dietary counseling); short-term inpatient care in a hospital, nursing facility, or hospice inpatient facility (including both respite care and care and procedures necessary for pain control and acute or chronic symptom management); continuous home care during periods of crisis, and only as necessary, to maintain the terminally ill individual at home; and any other item or service which is specified in the plan of care and for which payment may otherwise be made under Medicare, in accordance with Title XVIII of the Act.

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

Upon the implementation of the hospice benefit, 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.[3]

III. Provisions of the Proposed Rule

A. Proposed FY 2025 Hospice Wage Index and Rate Update

1. Proposed 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 Metropolitan Statistical Areas (MSAs), Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineations in these areas. This bulletin provided the delineations of all MSAs, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the 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 Combined Statistical Area

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

(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 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15, which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

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 above. 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 from above, 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, 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., if we adopt the revised OMB delineations this methodology would 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 are proposing that the proposed hospice wage index would be based on the FY 2025 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021 (FY 2021 cost report data). The proposed FY 2025 hospice wage index would not take into account any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The regulations that govern hospice payment do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor provisions that exist for IPPS hospitals. The reclassification provision found in section 1886(d)(10) of the Act is specific to hospitals. Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33) provides that the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. This rural floor provision is also specific to hospitals. Because the reclassification 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, skilled nursing facility prospective payment system (SNF PPS), inpatient rehabilitation facility prospective payment system (IRF PPS), and 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 0.8 by a 15 percent increase subject to a maximum wage index value of 0.8. The proposed 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.

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 of 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 proposed wage index value for Hinesville-Fort Stewart, Georgia is 0.8726.

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, we are proposing that rural North Dakota would now become a rural area without a hospital from which hospital wage data can be devised. Therefore, to calculate the wage index for rural area 99935, North Dakota, we are proposing 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 results in a proposed FY 2025 hospice wage index of 0.8446 for rural North Dakota.

Table 1: Wage Index For Rural North Dakota.

CBSA Code	CBSA Name	Hospice Wage Index
13900	Bismarck, ND	0.9020
22020	Fargo, ND-MN	0.8763
24220	Grand Forks, ND-MN	0.8000
33500	Minot, ND	0.8000
	Proposed FY 2025 Hospice Wage Index	**0.8446**

Note: CBSA 24220 Grand Forks, ND-MN and CBSA 33500 Minot, ND are adjusted by the hospice floor.

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, as part of our proposal to adopt the revised OMB delineations discussed further in section III.A.2.c. below, there would now be a hospital in rural Puerto Rico from which hospital wage data can be derived. Therefore, we are proposing 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 results in a proposed wage index of 0.4421.

Finally, we are proposing that for FY 2025, if the adoption of the revised OMB delineations is finalized 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. The proposed FY 2025 wage index for rural area 99908 Delaware would be 1.0429.

2. Proposed Implementation of New Labor Market Delineations

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, Combined Statistical Areas, 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 (CBSAs) (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 a more accurate and up-to-date payment system that reflects 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 are proposing 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. 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 Inpatient Prospective Payment System (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 became Micropolitan Areas, and some counties that once were part of a Micropolitan Area, and thus were treated as rural, have become urban based on the 2020 Decennial Census data. 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 are also proposing to continue to treat Micropolitan Areas as ''rural'' and to include Micropolitan Areas in the calculation of each State's rural wage index.

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 have evaluated the change and are proposing 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. We are providing the following crosswalk in Table 2 for counties located in Connecticut with the current and proposed FIPS county and county-equivalent codes and CBSA assignments.

BILLING CODE 4120–01–P

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 would become rural if we adopt as final our proposal to 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
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

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name
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 would be considered located in urban areas under the revised OMB delineations beginning in FY 2025. Table 4 lists the 54 counties that would be urban if we adopt as final our proposal to implement the revised OMB delineations.

TABLE 4: Rural Counties That Would Change to Urban Status

FIPS County Code	County Name	State	Proposed FY 2025 CBSA	Proposed 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

FIPS County Code	County Name	State	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name
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
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 section).

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

Current CBSA Code	Current CBSA Name	Proposed FY 2025 CBSA Code	Proposed 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

Current CBSA Code	Current CBSA Name	Proposed FY 2025 CBSA Code	Proposed FY 2025 CBSA Name
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
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	Proposed FY 2025 CBSA Code	Proposed 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 would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. In another type of change, some CBSAs have counties that would split off to become part of or to form entirely new labor market areas. For example, the District of Columbia, DC, Charles County, MD and Prince Georges County, MD would move from CBSA 47894 (Washington-Arlington-Alexandria, DC-VA-MD-WV) into CBSA 47764 (Washington, DC-Md). Calvert County, MD would move from CBSA 47894 (Washington-Arlington-Alexandria, DC-VA-MD-WV) into CBSA 30500 (Lexington Park, MD). The remaining counties that currently make up 47894 (Washington-Arlington-Alexandria, DC-VA-MD-WV) would move into CBSA 11694 (Arlington-Alexandria-Reston, VA-WV). Finally, in some cases, a CBSA would 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	Proposed FY 2025 CBSA	Proposed 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
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

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name
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
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

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name
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
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-	11694	Arlington-Alexandria-Reston, VA-WV

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name
				Alexandria, DC-VA-MD-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
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-	47764	Washington, DC-MD

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name
				Alexandria, DC-VA-MD-WV		
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

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f. Proposed 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 propose 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 are proposing for FY 2025, that the 5-percent cap would also be applied to counties that would move from a CBSA or statewide rural area with a higher wage index value into a new CBSA or rural area with a lower wage index value, so that the county's FY 2025 wage index would not be less than 95 percent of the county's FY 2024 wage index value under the old delineation despite moving into a new delineation with a lower wage index.

Due to the way that we propose 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 are proposing that beginning in FY 2025, counties that have a different wage index value than the CBSA or rural area into which they are designated after the application of the 5-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 are proposing 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.

Additionally, we are proposing 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 are also proposing 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 the 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 above, 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 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.

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

FIPS Code	County Name	State	FY 2024 CBSA	FY 2024 CBSA Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name	Proposed Transition Code
01129	WASHINGTON	AL	33660	Mobile, AL	99901	ALABAMA	50001
13171	LAMAR	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	99911	GEORGIA	50002
15005	KALAWAO	HI	99912	HAWAII	27980	Kahului-Wailuku, HI	50003
16077	POWER	ID	38540	Pocatello, ID	99913	IDAHO	50004
17183	VERMILION	IL	19180	Danville, IL	99914	ILLINOIS	50005
18133	PUTNAM	IN	26900	Indianapolis-Carmel-Anderson, IN	99915	INDIANA	50006
21101	HENDERSON	KY	21780	Evansville, IN-KY	99918	KENTUCKY	50007
24009	CALVERT	MD	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	30500	Lexington Park, MD	50008
24047	WORCESTER	MD	41540	Salisbury, MD-DE	99921	MARYLAND	50009
25011	FRANKLIN	MA	44140	Springfield, MA	99922	MASSACHUSETTS	50010
26155	SHIAWASSEE	MI	29620	Lansing-East Lansing, MI	99923	MICHIGAN	50011
27075	LAKE	MN	20260	Duluth, MN-WI	99924	MINNESOTA	50012
27133	ROCK	MN	99924	MINNESOTA	43620	Sioux Falls, SD-MN	50013
32019	LYON	NV	99929	NEVADA	39900	Reno, NV	50014
36123	YATES	NY	40380	Rochester, NY	99933	NEW YORK	50015
37077	GRANVILLE	NC	20500	Durham-Chapel Hill, NC	99934	NORTH CAROLINA	50016
37087	HAYWOOD	NC	11700	Asheville, NC	99934	NORTH CAROLINA	50017
39123	OTTAWA	OH	45780	Toledo, OH	41780	Sandusky, OH	50018
42103	PIKE	PA	35084	Newark, NJ-PA	99939	PENNSYLVANIA	50019
51113	MADISON	VA	47894	Washington-Arlington-	99949	VIRGINIA	50020

				Alexandria, DC-VA-MD-WV			
51175	SOUTHAMPTON	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC	99949	VIRGINIA	50021
51620	FRANKLIN CITY	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC	99949	VIRGINIA	50021
54057	MINERAL	WV	19060	Cumberland, MD-WV	99951	WEST VIRGINIA	50022
72001	ADJUNTAS	PR	38660	Ponce, PR	99940	PUERTO RICO	50023
72023	CABO ROJO	PR	41900	SanGermán, PR	32420	Mayagüez, PR	50024
72055	GUANICA	PR	49500	Yauco, PR	99940	PUERTO RICO	50025
72079	LAJAS	PR	41900	San Germán, PR	32420	Mayagüez, PR	50024
72081	LARES	PR	10380	Aguadilla-Isabela, PR	99940	PUERTO RICO	50026
72083	LAS MARIAS	PR	32420	Mayagüez, PR	99940	PUERTO RICO	50027
72121	SABANA GRANDE	PR	41900	San Germán, PR	32420	Mayagüez, PR	50024
72125	SAN GERMAN	PR	41900	San Germán, PR	32420	Mayagüez, PR	50024
72141	UTUADO	PR	10380	Aguadilla-Isabela, PR	99940	PUERTO RICO	50026

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The proposed wage index applicable to FY 2025 provides a crosswalk between the FY 2025 wage index using the current OMB delineations and the FY 2025 wage index using the proposed revised OMB delineations that would be in effect in FY 2025 if these proposed changes are finalized. This file shows each State and county and its corresponding proposed wage index along with the previous CBSA number, the proposed CBSA number or alternate identification number, and the proposed CBSA name. The proposed 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-regulations-and-notices.*

3. Proposed 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 according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient hospital market basket percentage increase for that FY. In the FY 2022 IPPS final rule, we finalized the rebased and revised IPPS market basket to reflect a 2018 base year. We refer readers to the FY 2022 IPPS final rule (86 FR 45194) 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 is 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 is 0.4 percentage point (based on IGI's fourth quarter 2023 forecast). Therefore, the proposed hospice payment update percentage for FY 2025 is 2.6 percent. We also propose that if more recent data become available after the publication of this 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. Therefore, we are proposing to update hospice payments using the methodology outlined and apply the 2018-based IPPS market basket percentage increase for FY 2025 of 3.0 percent, reduced by the statutorily required productivity adjustment of 0.4 percentage point along with the wage index budget neutrality adjustment to update the payment rates. For the FY 2025 hospice wage index, we are proposing to use the FY 2025 pre-floor, pre-reclassified IPPS hospital wage index with the proposed revised OMB labor market delineations as its basis.

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.

4. Proposed 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 are proposing to use FY 2023 claims data as of January 11, 2024 for the proposed FY 2025 payment rate updates. We note that the budget neutrality factors and payment rates will 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 proposed 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 proposed FY 2025 RHC rates are shown in Table 9. The FY 2025 payment rates for CHC, IRC, and GIP are shown in Table 10.

TABLE 9: Proposed 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	Proposed FY 2025 Payment Rates
651	Routine Home Care (days 1-60)	$218.33	1.0009	0.9983	1.026	$223.83
651	Routine Home Care (days 61+)	$172.35	1.0000	0.9975	1.026	$176.39

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

Code	Description	FY 2024 Payment Rates	Wage Index Standardization Factor	FY 2025 Hospice Payment Update	Proposed FY 2025 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,565.46	1.0026	1.026	$1,610.34 ($67.10 per hour)
655	Inpatient Respite Care	$507.71	0.9947	1.026	$518.15
656	General Inpatient Care	$1,145.31	0.9931	1.026	$1,166.98

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 two 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 two to four percentage points. 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. We applied this policy beginning with the FY 2024 Annual Payment Update (APU), which we based on CY 2022 quality data. Therefore, the proposed FY 2025 rates for hospices that do not submit the required quality data would be updated by −1.4 percent, which is the proposed FY 2025 hospice payment update percentage of 2.6 percent minus four percentage points. These rates are shown in Tables 11 and 12.

TABLE 11: Proposed FY 2025 Hospice RHC Payment Rates for Hospices That DO NOT 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 2.6% minus 4 percentage points = -1.4%	Proposed FY 2025 Payment Rates
651	Routine Home Care (days 1-60)	$218.33	1.0009	0.9983	0.9860	$215.10
651	Routine Home Care (days 61+)	$172.35	1.0000	0.9975	0.9860	$169.51

TABLE 12: Proposed 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 2.6% minus 4 percentage points = -1.4%	Proposed FY 2025 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,565.46	1.0026	0.9860	$1,547.56 (64.48 per hour)
655	Inpatient Respite Care	$507.71	0.9947	0.9860	$497.95
656	General Inpatient Care	$1,145.31	0.9931	0.9860	$1,121.48

5. Proposed 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. 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 of 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 propose 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 is $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 propose that if more recent data become available after the publication of this 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.

B. Proposed Clarifying Regulation Text Changes

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 section 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 should be proposed to the medical director CoP for clarity and consistency. To align the medical director CoP and the hospice payment requirements, we propose 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 propose to amend the medical director CoP § 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 proposed rule for additional proposals regarding the payment requirements for 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.

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) and hospice medical director or physician member of the hospice interdisciplinary group (IDG) to certify in writing at the beginning in 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 Conditions of Participation (CoP) 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 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 ''medical director of the hospice'' or the ''physician member of the hospice interdisciplinary group'' 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. In order to align §§ 418.22(b) and 418.25 with the CoPs at § 418.102, we propose 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 are clarifying that this does not connote a change in policy; rather we believe aligning the language at §§ 418.22(b) and 418.25 with the CoPs at § 418.102 allows for greater clarity and consistency between key components of hospice regulations and policies.

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 Medicare Administrative Contractor (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 propose to reorganize the language in this section to clearly denote the differences between the election statement and the NOE. That is, we are proposing to title § 418.24(b) as ''Election Statement'' and would include the title ''Notice of Election'' at § 418.24(e). By clearly titling this section, the requirements for the election statement and the notice of election would be distinguished from one another, mitigating any confusion between the two documents. These changes align with existing subregulatory guidance. This reorganization would not be a change in policy, rather it is intended to more clearly identify the requirements for the election statement and the NOE by reorganizing the structure of the regulations. 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 invite comments on the clarifying regulation text changes and reorganization as described in sections II.B. of this proposed rule.

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

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 interdisciplinary group (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 to those services that enforce 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.[4] 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 [5] 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.[6]

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 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 are soliciting public comment on the following questions:

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

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. 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

[4] 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.

[5] 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.

[6] 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.

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) web pages 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.

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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

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2. Proposal To Implement 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 proposed rule, we propose adding two process measures no sooner than CY 2027 to the HQRP calculated from data collected from HOPE: *Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Symptom Impact.* We propose to use the data collected from HOPE (see section III. D 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. We propose these two measures would determine whether a follow-up visit occurs within 48 hours 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.

Therefore, we propose these new concepts on timely reassessment 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/reassessment within 48 hours to ensure treatment has helped alleviate and/or manage those symptoms. Therefore, we are proposing two process measures derived from HOPE data—*Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Symptom Impact*—would 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 and safer 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 take into account 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 proposed *Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Symptom Impact* measures will add value to HQRP by filling an identified informational gap in the current measure set. Specifically, the proposed *Timely Reassessment of Pain Impact* process measure will determine how many patients assessed with moderate or severe pain impact were reassessed by the hospice within two calendar days, and the proposed *Timely Reassessment of Non-Pain Symptom Impact* process measure will determine how many patients assessed with moderate or severe non-pain impact were reassessed by the hospice within two calendar days. Compared to the single existing HQRP measure that includes pain symptom assessment, the two proposed HOPE-based process measures will better reflect hospices' efforts to alleviate patients' symptoms on an ongoing basis.

b. Proposed Specifications of the Measures

We proposed 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 web page at *https://www.cms.gov/medicare/quality/hospice/hope* and the PRA package that accompanies this proposed rule can be accessed at *https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing.* We propose that only in-person visits would count for the collection of data for these proposed measures—that is, telehealth calls would not count for a reassessment. We seek 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 propose 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).

For both the proposed *Timely Reassessment of Pain Impact* and proposed *Timely Reassessment of Non-Pain Symptom Impact* measures, we propose 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, we proposed that 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 reassessment visit, the hospice was unable to contact the patient/caregiver to perform the reassessment, the patient traveled outside the service area, or the patient was in the ER/hospital during the two-day follow-up window. In these situations, we propose that a hospice would be unable to conduct a reassessment due to circumstances beyond their control, and therefore these situations will not be included in the measure denominator.

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

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 web page 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 proposed process quality measures has thus far relied on data from the HOPE beta (field) test. We propose 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 web page. 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 reassessment aligned with their usual practices. In this proposed rule, we solicit public comments on these two process measures.

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 Reassessment of Pain Impact* and *Timely Reassessment of 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 web page. 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 web page, 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/*.

3. Proposal To Implement the 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 propose to begin collecting the HOPE standardized patient level data collection tool on or after October 1, 2025, for proposed quality measures discussed in section 2. We propose that the HOPE assessment instrument would replace the HIS upon implementation, as discussed in section III. D6(b). 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 would provide data for the HQRP quality measures and its requirements through standardized data collection; and provide additional clinical data that could inform future payment refinements. All data collected by the instrument are expected to be used for quality measures, as authorized under section1814(i)(5)(C) of the Act, and only for quality measures under section1814(i)(5)(D), of the Act, which will include the measures *Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Symptom Impact* measures proposed in this Rule.

HOPE would be a component of implementing high-quality and safe hospice care for patients, Medicare beneficiaries and non-beneficiaries alike. HOPE would also contribute to the patient's plan of care through providing patient data throughout the hospice stay. We propose to collect data from multiple time points across the hospice stay, that would inform hospice providers potentially resulting in improved practice and care quality. Additional information about the draft HOPE tool 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 proposed rule. CMS 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 draft 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.

We propose to adopt and implement HOPE as a standardized patient element set to replace the current Hospice Item Set (HIS). HOPE v1.0 would contain demographic, record processing, and patient-level standardized data elements that would be collected by all Medicare-certified hospices for all patients over the age of 18, regardless of payer source, to support HQRP quality measures. We propose new HOPE data elements that are 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. We propose that HOPE data would be collected by hospice staff for each patient admission at three distinct time points: admission, the hospice update visit (HUV), and discharge, as discussed in the PRA as well as sections IV. A of this proposed rule in which we discuss Collection of Information requirements and the Regulatory Impact Analysis. We propose 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. We propose that HOPE data 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 proposed draft HOPE Guidance Manual and PRA, not all HOPE items would be required to be completed at every timepoint. These proposed time points could also be revised in future rulemaking.

We propose that HOPE data collection would be effective beginning on or after October 1, 2025 to support the proposed quality measures anticipated for public reporting on or after CY 2027. After HOPE implementation, hospices would 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 below in section III. D6, Form, Manner, and Timing of Quality Measure Data Submission, and section IV., Collection of Information.

We propose to update § 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 proposed change is intended to 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 would 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 section1814(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 proposed data collection beginning on or after October 1, 2025. We propose to provide information about upcoming provider trainings related to HOPE v1.0 that will be posted on the *CMS HQRP website* on the *Announcement and Spotlight* page and announced during Open Door Forums. Past trainings about the HQRP are available through the *HQRP Training and Education Library*. These trainings will help providers understand the requirements necessary to be successful with the HQRP, including how data collected via the new draft HOPE tool is submitted for quality measures and contributes to compliance with the HQRP.

The draft HOPE Guidance Manual v1.0 is available on the HQRP HOPE web page for review and the final HOPE Guidance Manual v1.0 will be available 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 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 website, 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 propose that the data from the first quarter (anticipated to be Q4 CY2025, if HOPE data collection begins in October 2025) will not be used for assessing validity and reliability of the quality measures.

We propose to 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 propose to 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 website 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 propose that public reporting of the proposed quality measures will be implemented no earlier than FY 2027. Alternatively, we propose public reporting may occur during the FY 2028 APU year, allowing ample time for data analysis, review of measures' appropriateness for use for public reporting, and allowing hospices the required time to review their own data prior to public reporting.

CMS will consider public reporting using fewer than four (4) quarters of data for the initial reporting period, but we propose 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 propose to 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 2024 2025 through Q3 2025 2026, then public reporting of HOPE will be based on Q1 2025 2026, Q2 2025 2026, and Q3 2025 2026. The next public reporting period would include Q1 2025 2026–Q4 2025 2026, and public reporting would be based on four (4) quarters of data, as would all subsequent rolling reporting periods.

We will propose the timeline for public reporting of data in future rulemaking and we welcome public comment on what we should consider when developing future proposals related to public reporting.

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 web page: *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 [7] and testing the

[7] 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

Continued

Accountable Health Communities (AHC) model under section 1115A of the Social Security Act.[8]

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 under 1890(a) 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.[9] 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.[10] 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.

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 [11] and a Biden-Harris Administration priority.[12] 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 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.

CMS requests input on which of the 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.[13] [14] 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.[15] 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. Homelessness is defined as ''lacking a regular nighttime residence or having a primary nighttime residence that is a temporary shelter or other place not designed for sleeping.'' [16] On a single night in 2023, roughly 653,100 people, or 20 out of every 10,000 people in the United States, were experiencing

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.

[8] 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.*

[9] 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.*

[10] 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.*

[11] 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.*

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

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

[14] 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.

[15] 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.

[16] *https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability.*

homelessness.[17] 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.[18] Food insecurity has been a priority for the Biden-Harris Administration, with the White House recently announcing 141 stakeholder funding commitments to support the White House Challenge to End Hunger and Build Healthy Communities.[19] 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.[20] 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.'' [21] While having enough food is one of many predictors for health outcomes, a diet low in nutritious foods is also a factor.[22] 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. About 50 percent of older adults are affected by malnutrition, which is further aggravated by a lack of food security and poverty.[23]

[17] 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.*

[18] 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/.*

[19] *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/.*

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

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

[22] 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.*

[23] 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.*

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 c. Often not enough to eat	https://www.aamc.org/media/25736/download
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 Challenges

A lack of energy (utility) security can be defined as an inability to adequately meet basic household energy needs.[24] According to the Department of Energy, one in three households in the US are unable to adequately meet basic household energy needs.[25] 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.[26] 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 and African American households.[27] 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 the elderly, children, the socioeconomically disadvantaged, and the medically vulnerable.[28] 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.

[24] 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.

[25] U.S. 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/.*

[26] 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.*

[27] 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/.*

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

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 Challenges

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 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 solicit 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?

5. Proposed 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 proposing changes to the CAHPS Hospice Survey and administrative protocol. The revised survey is shorter and simpler than the current survey and includes new questions on topics suggested by stakeholders. Specifically, proposed changes to the survey and the quality measures derived from testing include:

- Removal of three nursing home items and an item about moving the family member [29] that are not included in scored measures.
- Removal of one survey item regarding confusing or contradictory information from the Hospice Team Communication measure.[30]
- Replacement of the multi-item Getting Hospice Care Training measure [31] 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 are on the 2023 Measures Under Consideration list (MUC2023–183,191 & 192) and are under evaluation by the Pre-Rulemaking Measure Review (PRMR) Post-Acute Care/Long-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.

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

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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 are for removal from this version of the survey are: Question 32 through 34 (nursing home items), Question 30 (item about moving a family member), Question 10 (item regarding confusing or contradictory information), and Question 17 through 20, 23, 28, and 29 (screening and evaluative items used to calculate the Getting Hospice Care Training measure).

[30] Ibid.

[31] Ibid.

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

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

Measure	Item(s) in Current Measure	Item(s) in Proposed Revised or New Measure
	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	"How often did you feel that the hospice team really cared about

Measure	Item(s) in Current Measure	Item(s) in Proposed Revised or New Measure
	feel that the hospice team really cared about your family member?"	your family member?"
Getting Help for Symptoms	"Did your family member get as much help with pain as he or she needed?"	"Did your family member get as much help with pain as they needed?"
	"How often did your family member get the help he or she needed for trouble breathing?"	"How often did your family member get the help they needed for trouble breathing?"
	"How often did your family member get the help he or she needed for trouble with constipation?"	"How often did your family member get the help they needed for trouble with constipation?"
	"How often did your family member get the help he or she needed <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 Religious Support	"Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs. While your family member was in hospice care, how much support for your religious and	"Support for religious, spiritual, or cultural beliefs may include talking, praying, quiet time, and respecting traditions. While your family member was in hospice care, how much support for your religious, spiritual, and cultural beliefs did

Measure	Item(s) in Current Measure	Item(s) in Proposed Revised or New Measure
	spiritual beliefs did you get from the hospice team?"	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	N/A (removed from revised survey)

Measure	Item(s) in Current Measure	Item(s) in Proposed Revised or New Measure
	your family member?"	
	"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?"

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We seek comment on these proposed changes before finalization.

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 propose 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 November 2027, with scores calculated using data from Q1 2025 through Q4 2026. Because measure scores are calculated quarterly and Star Ratings are calculated every other quarter, these changes may be introduced in different quarters for measure scores and Star Ratings. In the interim period, measure scores would be made available to hospices confidentially in their Provider Preview reports once they met a threshold number of completed surveys.

We believe the proposed 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, we propose that 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 proposing to add a web-mail mode (email invitation to a web survey, with mail follow-up to non-responders); to add a pre-notification letter; and to extend the field period from 42 to 49 days, beginning with January 2025 decedents. The 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.

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 proposal 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 proposes updating 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 proposing 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 proposing to use mail-only as the reference mode beginning with January 2025 decedents as most surveys are currently completed in the mail-only mode. We invite public comment on the CAHPS Hospice Survey proposals.

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).

We propose that hospices 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 would 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 date specifications for software developers and vendors on the CMS website. 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 all required HOPE assessments to CMS for at least 90% of their patients will be subject to a 4% 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 HIS data, and subsequently 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 propose to apply the same submission requirements for HOPE admission, discharge, and two HUV records. After HIS is phased out, hospices would 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.

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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 or discharge) for patient admissions/discharges occurring 1/1/24-12/31/24	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2024-12/31/2024
FY 2027	Submit at least 90 percent of all HIS/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.

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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 web pages at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting.* We also encourage readers to visit the HQRP web page and sign-up for the Hospice Quality ListServ to stay informed about HQRP.

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 requires that we solicit comment on the following issues:

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

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

A. Hospice Outcomes & Patient Evaluation (HOPE)

As proposed in section III. of this proposed rule, we are proposing the use of HOPE to collect QRP information through revisions to § 418.312(b). We are also proposing to require 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. HOPE would be used to support the standardized collection of the requisite data elements to calculate quality measures being utilized by the QRP. Hospices would 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 proposed 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 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 timepoint, 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 web page 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 × 490 HOPE records per year/60 minutes × $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, as seen above) with the total clerical staff cost burden (5 minutes × 490 HOPE Records per each hospice per year/60 minutes per hour × $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 × 5,640 hospices). Table 18 below provides the summary of changes in burden relative to the new HOPE Admission, Update Visit and Discharge timepoints. This increase in incremental burden is explained further in the Regulatory Impact Analysis (RIA) section of this proposed rule, and is also discussed in detail in the Information Collection Request accompanying this rulemaking.

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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**

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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 proposal would not impose any additional collection of information burden on hospices for the forthcoming Fiscal Year.

V. Response to Comments

Because of the large number of public comments we normally receive on

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

VI. Regulatory Impact Analysis

A. Statement of Need

1. Hospice Payment

This proposed rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the Hospice Wage Index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This proposed rule would update 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 proposed rule would update 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 would 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 proposed quality measures included in this proposed 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 proposed 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 rulemaking 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 proposed rule meets the criteria set forth in 5 U.S.C. 804(2).

1. Hospice Payment

We estimate that the aggregate impact of the payment provisions in this rulemaking would result in an estimated increase of $705 million in payments to hospices, resulting from the proposed hospice payment update percentage of 2.6 percent for FY 2025. The impact analysis of this proposed 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 January 11, 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 proposed 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 proposed 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 proposed in section III. of this proposed 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 above, we estimate an annual cost burden of $184,729,739 across all hospices ($32,764.67 per hospice × 5,640 hospices) starting in FY 2026.

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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 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**

Our proposal would 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 × 5,640 hospices). This burden is also discussed in detail as part of an accompanying PRA submission.

C. Detailed Economic Analysis

1. Proposed Hospice Payment Update for FY 2025

The FY 2025 proposed hospice payment impacts appear in Table 19. 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 proposed hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act and is consistent for all providers. The proposed hospice payment update percentage of 2.6 percent is based on the proposed 3.0 percent inpatient hospital market basket percentage increase reduced by a proposed 0.4 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 of all the proposals 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 January 11, 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 of all the proposals

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 Proposed Hospice Payment Update (%)	Overall Total Impact for FY 2025
All Hospices	6,044	0.0%	2.6%	2.6%
Hospice Type and Control				
Freestanding/Non-Profit	550	0.2%	2.6%	2.8%
Freestanding/For-Profit	4,012	0.0%	2.6%	2.6%
Freestanding/Government	37	-0.6%	2.6%	2.0%
Freestanding/Other	362	-0.1%	2.6%	2.5%
Facility/HHA Based/Non-Profit	316	-0.7%	2.6%	1.9%
Facility/HHA Based/For-Profit	189	0.1%	2.6%	2.7%
Facility/HHA Based/Government	71	0.2%	2.6%	2.8%
Facility/HHA Based/Other	84	-0.9%	2.6%	1.7%
Subtotal: Freestanding Facility Type	4,961	0.1%	2.6%	2.7%
Subtotal: Facility/HHA Based Facility Type	660	-0.5%	2.6%	2.1%
Subtotal: Non-Profit	866	0.0%	2.6%	2.6%
Subtotal: For Profit	4,204	0.1%	2.6%	2.7%
Subtotal: Government	108	-0.2%	2.6%	2.4%
Subtotal: Other	446	-0.2%	2.6%	2.4%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	123	-0.1%	2.6%	2.5%
Freestanding/For-Profit	350	0.3%	2.6%	2.9%
Freestanding/Government	22	-0.1%	2.6%	2.5%
Freestanding/Other	55	0.5%	2.6%	3.1%
Facility/HHA Based/Non-Profit	117	0.2%	2.6%	2.8%
Facility/HHA Based/For-Profit	52	0.5%	2.6%	3.1%
Facility/HHA Based/Government	55	0.4%	2.6%	3.0%
Facility/HHA Based/Other	46	0.0%	2.6%	2.6%
Hospice Type and Control: Urban				

Freestanding/Non-Profit	427	0.2%	2.6%	2.8%
Freestanding/For-Profit	3,662	0.0%	2.6%	2.6%
Freestanding/Government	15	-0.8%	2.6%	1.8%
Freestanding/Other	307	-0.2%	2.6%	2.4%
Facility/HHA Based/Non-Profit	199	-0.9%	2.6%	1.7%
Facility/HHA Based/For-Profit	137	0.0%	2.6%	2.6%
Facility/HHA Based/Government	16	0.1%	2.6%	2.7%
Facility/HHA Based/Other	38	-1.1%	2.6%	1.5%
Hospice Location: Urban or Rural				
Rural	823	0.2%	2.6%	2.8%
Urban	5,221	0.0%	2.6%	2.6%
Hospice Location: Region of the Country (Census Division)				
New England	148	-1.4%	2.6%	1.2%
Middle Atlantic	280	-0.6%	2.6%	2.0%
South Atlantic	607	0.8%	2.6%	3.4%
East North Central	604	0.0%	2.6%	2.6%
East South Central	251	0.9%	2.6%	3.5%
West North Central	416	0.1%	2.6%	2.7%
West South Central	1,150	0.6%	2.6%	3.2%
Mountain	605	1.6%	2.6%	4.2%
Pacific	1,935	-1.8%	2.6%	0.8%
Outlying	48	-1.5%	2.6%	1.1%
Hospice Size				
0 - 3,499 RHC Days (Small)	1,600	-0.9%	2.6%	1.7%
3,500-19,999 RHC Days (Medium)	2,718	-0.2%	2.6%	2.4%
20,000+ RHC Days (Large)	1,726	0.1%	2.6%	2.7%

Source: FY 2023 hospice claims data from CCW accessed on January 11, 2024.
Note: The overall total impact reflects the addition of the individual impacts, which includes the updated wage index data and revised OMB delineations, as well as the 2.6 percent market basket update.
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 6,044). Subtypes involving ownership only add up to 5,624 while subtypes involving facility type only add up to 5,621.
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; expiration 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 would incur costs related to the transition from HIS to HOPE. These costs would 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 would also incur costs for help-desk support that must be provided to assist hospices with the data submission process. There would 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 estimate is the same as the current estimated costs to the Federal Government associated with HIS, HOPE implementation and ongoing maintenance would not incur additional annual costs.

The estimated 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	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	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 below 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**

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

3. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review this rulemaking, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this proposed rule. We welcome any comments on the approach to estimating the number of entities that will review this proposed rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rulemaking. We are soliciting public comments on this assumption.

Using the occupational wage information from the BLS for medical and health service managers (Code 11–9111) from May 2022; we estimate that the cost of reviewing this rulemaking is $100.80 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes119111.htm*). This proposed rule consists of approximately 34,385 words. Assuming an average reading speed of 250 words per minute, it would take approximately 1 hour for staff to review half of it. For each hospice that reviews the proposed rule, the estimated cost is $100.80 (1 hour × $100.80). Therefore, we estimate that the total cost of reviewing this regulation is $8,064.00 ($100.80 × 80 reviewers).

D. Alternatives Considered

1. Hospice Payment

For the FY 2025 Hospice Wage Index and Rate Update proposed rule, we considered alternatives to the proposals articulated in section III.A of this proposed 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 payment update percentage. The proposed 2.6 percent hospice payment update percentage for FY 2025 is based on a

proposed 3.0 percent inpatient hospital market basket update for FY 2025, reduced by a proposed 0.4 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 proposing 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.

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 proposed 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 rulemaking. 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 January 11, 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	$705 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 $705 million in transfer payments is a result of the 2.6 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 rulemaking 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.[32] Table 23 shows the number of firms, revenue, and estimated impact per home health care service category.

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 proposed in this rulemaking 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 proposed 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 2.6 percent or approximately $705 million in increased revenue to hospices in FY 2025. The 2.6 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 19 and is driven solely by the impact of the hospice payment update percentage reflected in the fifth column of the impact table. In addition, small hospices would experience a greater estimated increase (X percent), compared to large hospices (X percent) due to the proposed updated wage index. Further detail is presented in Table 19 by hospice type and location.

We estimate that the new impact of the proposed HQRP data collection requirements would be $32,764.81 per hospice. While small hospices would be estimated to 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a MSA and has fewer than 100 beds. This rulemaking would only affect hospices. Therefore, the Secretary has determined that this proposed rule would 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

[32] 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.*

threshold is approximately $183 million. This rulemaking is anticipated to 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 rulemaking under these criteria of Executive Order 13132 and have determined that it will not impose substantial direct costs on State or local governments.

I. Conclusion

We estimate that aggregate payments to hospices in FY 2025 would increase by $705 million as a result of the proposed hospice payment update, compared to payments in FY 2024. We estimate that in FY 2025, hospices in urban areas would experience, on average, a 2.6 percent increase in estimated payments compared to FY 2024; while hospices in rural areas would experience, on average, a 2.8 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 4.2 percent. Hospices serving patients in areas in the Pacific regions would experience, on average, the lowest estimated increase of 0.8 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 March 20, 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 proposes to amend 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 a new 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. Amend § 418.25 by revising paragraph (a) and paragraph (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 paragraph (b) introductory text and paragraph (c) to read as follows:

§ 418.102 Condition of participation: Medical director.

* * * * *

(b) *Standard: Initial certification of terminal illness.* The medical director (or physician designee, if the medical director is unavailable, as defined in § 418.3 of this section) 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, if the medical director is unavailable, as defined in § 418.3 of this section) or physician member of the IDG must review the patient's clinical information.

* * * * *

§ 418.309 [Amended]

■ 6. Section 418.309 is amended in paragraphs (a)(1) and (2) by removing ''2032'' and adding in its place ''2033''.

■ 7. 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.

* * * * *

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2024–06921 Filed 3–28–24; 4:15 pm]

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