July 30, 2021

CMS Issues Final FY2022 Hospice Payment Rule and Quality Reporting Program Update

Payment Update drops to 2.0%, "Labor Shares" Undergo Slight Adjustment

Late on Thursday, July 29, the Centers for Medicare & Medicaid Services (CMS) released a final rule governing hospice payment and policy changes for fiscal year 2022 (FY2022). While the final rule does not stray far from that proposed on April 8, there are some changes: the final payment update is now scheduled to be two percent (as opposed to the 2.3 percent proposed update) and CMS has slightly modified some of the proposed labor shares over what were originally proposed.

The rule, Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements and is scheduled to be published in the Federal Register on August 4.

The rule becomes effective October 1, 2021.

Hospice Utilization and Spending Patterns

In the FY 2022 proposed rule CMS provided data analysis on hospice utilization trends from FY 2010 through FY 2019. The analysis included data on the number of beneficiaries using the hospice benefit, live discharges, reported diagnoses on hospice claims, Medicare hospice spending, and Parts A, B and D non-hospice spending during a hospice election.

The proposed rule also solicited comments from the public, hospice providers, patients and advocates regarding hospice utilization and spending patterns. It also solicited comments regarding skilled visits in the last week of life, particularly, what factors determine how and when visits are made as an individual approaches the end of life and how hospices make determinations as to what items, services and drugs are related versus unrelated to the terminal illness and related conditions. That is, how do hospices define what is unrelated to the terminal illness and related conditions when establishing a hospice plan of care?

The rule further solicited comments on what other factors may influence whether or how certain services are furnished to hospice beneficiaries.

Finally, the rule requested feedback from stakeholder as to whether the hospice election statement addendum has changed the way hospices make care decisions and how the addendum is used to prompt discussions with beneficiaries and non-hospice providers to ensure that the care needs of beneficiaries who have elected the hospice benefit are met.

In response to comments CMS indicated that it plans to continue to monitor hospice trends and vulnerabilities and will consider the various comments and suggestions submitted for ongoing monitoring analyses program integrity efforts, and for potential future rulemaking.

FY2022 Revisions to and Rebasing of the Hospice Labor Shares

CMS has indicated interest in potential changes to the labor/non-labor shares of the hospice payment rates, particularly given the collection of expanded data as part of the revised hospice cost report. As part of the FY2022 rule, CMS is finalizing its proposed rebasing of and revisions to the labor shares for

Continuous Home Care (CHC), Routine Home Care (RHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP) using 2018 cost report data for freestanding hospices. CMS elected not to use provider-based cost reports because few providers passed the Level I edits, so these reports were not usable.

While CMS has indicated that it is finalizing the new labor shares for each level of hospice care largely as proposed, they have made some modifications to the methodology based on comments received from the public. The specific area of concern relates to CMS' failure to include contracted medical director costs as part of its calculation. This was a concern voiced in comments by NAHC and others. As a result, CMS revised its calculations to incorporate both contracted medical director costs and contracted nursing administration costs. This revision to the labor share methodology results in upward revisions to the proposed labor shares for each of the levels of care (between 0.6 percentage point and 1.1 percentage point).

In response to comments requesting greater detail around what frequency CMS will use to revise the labor shares in the future, CMS indicated that labor shares for other prospective payment systems are typically rebased every four to five years. CMS tentatively plans to rebase the hospice labor shares on a similar schedule. However, in light of the COVID-19 public health emergency, CMS plans to monitor the upcoming Medicare cost report data (for 2020) to see if a more frequent revision to the hospice labor shares is necessary in order to reflect the most recent cost structures of hospice providers. Any future revisions to the hospice labor shares will be proposed and subject to public comments in future rulemaking.

CMS also indicated, in response to public comments, that it will evaluate and consider any future changes to the hospice cost report that will allow for the collection of data that may improve the calculation of the hospice labor shares, and will monitor compensation cost weights reported by hospices over time to determine if changes to the labor shares are appropriate.

CMS arrived at the following proposed labor shares by level of care, as compared with current labor shares:

	Final FY2022	Proposed FY2022	Current Labor Shares
• Continuous Home Care	75.2%	74.6%	68.71%
• Routine Home Care	66.0%	64.7%	68.71%
• Inpatient Respite Care	61.0%	60.1%	54.13%
• General Inpatient Care	63.5%	62.8%	64.01%

FY 2022 Hospice Wage Index and Rate Update

As part of the FY2021 Hospice Wage Index final rule, CMS incorporated changes from recent OMB bulletins that impacted wage index values for hospice and other providers of sufficient magnitude that CMS imposed a 5% cap on any decrease in a geographic area's wage index between FY2020 and FY2021. There are no such changes for FY2022, and hospice providers should take note that the 5% cap on any reduction in the wage index value (applied for FY2021) will be lifted for FY2022, and the full impact of the FY2021 changes will be felt.

The hospice payment update percentage for FY2022 is based on the finalized inpatient hospital market basket update of 2.7%, less the economy-wide productivity adjustment, which has been updated to 0.7 percent. As a result, the final hospice payment update will be 2.0%. This is 0.3 percentage point LOWER than proposed in April.

Based on the 2.0% payment update, CMS is proposing the following payment rates for FY2022*:

	FY2021 Payment Rates	FINAL FY2022 Payment Rates
• Routine Home Care (days 1-60)	$199.25	$203.40
• Routine Home Care (days 61+)	$157.49	$160.74
• Continuous Home Care	$1,432.41 ($59.68/hour)	$1,462.52 ($60.94/hour)
• Inpatient Respite Care	$461.09	$473.75
• General Inpatient Care	$1,045.66	$1,068.28

*Hospices that fail to comply with the HQRP reporting requirements will be subject to a 2% reduction of the above rates. Further, these rates do not reflect the 2% Medicare sequester.

The hospice Aggregate Cap amount for FY2022 is $31,297.61. As with the hospice payment rates, this value is slightly lower due to the increase in the productivity adjustment.

Clarifying Regulation Text Changes for the Hospice Election Statement Addendum

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), CMS finalized modifications to the hospice election statement and included a new condition for payment requiring a hospice, upon request, to provide the beneficiary (or representative) an election statement addendum outlining the items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. A signed addendum connotes that the hospice discussed the addendum and its contents with the beneficiary (or representative). Additionally, if a beneficiary (or representative) does not request the addendum, CMS expects hospices to document, in some fashion, that an addendum has been discussed with the patient (or representative) at the time of election, similar to how other patient and family discussions are documented in the hospice's clinical record.

As part of the proposed FY2022 rule (and again in the final FY2022 rule), CMS underscores that it is necessary for the hospice to document that the addendum was discussed and whether or not it was requested, in order to prevent potential claim denials related to any absence of an addendum (or addendum update) in the medical record.

As part of the final rule, CMS indicates it is finalizing various clarifications as proposed, with one exception. Following are the items finalized as part of the rule:

CMS proposed, and is finalizing, that hospices may furnish the addendum within 5 days from the date of a beneficiary or representative request, if the request is within 5 days from the date of a hospice election. For example, if the patient elects hospice on December 1st and requests the addendum on December 3rd, the hospice would have until December 8th to furnish the addendum. As a result, hospices will not be held to the three-day standard that would otherwise apply for an addendum requested "during the course of care."

CMS proposed, and is finalizing a clarification in regulation § 418.24(c)(10) that the "date furnished" must be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date. CMS will require that the hospice includes the "date furnished" in the patient's medical record and on the addendum itself.

In situations where the beneficiary or representative refuses to sign the addendum CMS indicated in the proposed FY2022 rule that the hospice document clearly in the medical record and on the addendum itself the reason the addendum is not signed in order to mitigate a claims denial for this condition for payment. In such a case, although the beneficiary has refused to sign the addendum, the "date furnished" must still be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative request, depending on when such request was made), and noted in the chart and on the addendum itself. As part of the final rule, CMS has determined that hospices are only required to document the reason the addendum is not signed on the addendum itself, and that separate documentation in the medical record is not required.

CMS will finalize a clarification in regulation that if only a non-hospice provider or Medicare contractor requests the addendum (and not the beneficiary or representative) the non-hospice provider is not required to sign the addendum, and CMS would not expect a signed copy to be included in the patient's medical record.

In instances where the beneficiary or representative requests the addendum at the time of election but dies prior to signing the addendum, CMS will finalize conforming regulatory text changes at § 418.24(c) to reflect the current policy that the hospice would not be required to furnish the addendum as the requirement would be deemed as being met.

If the patient revokes or is discharged within the required timeframe for supply of the addendum (3 or 5 days after a request, depending upon when such request was made), but the hospice has not yet furnished the addendum, the hospice is not required to furnish the addendum (§ 418.24(d)(4)).

In the event that a beneficiary requests the addendum, and the hospice furnishes the addendum within 3 or 5 days (depending upon when the request for the addendum was made), but the beneficiary dies, revokes, or is discharged prior to signing the addendum, a signature from the individual (or representative) is no longer required (418.24(d)(5)). CMS would continue to expect that the hospice would note the date furnished in the patient's medical record and on the addendum, if the hospice has already completed the addendum, as well as an explanation in the patient's medical record noting that the patient died, revoked, or was discharged prior to signing the addendum.

CMS is finalizing conforming regulatory text changes at § 418.24(c) in alignment with previous subregulatory guidance indicating that hospices have "3 days," rather than "72 hours" to meet the requirement to furnish the addendum when a patient requests the addendum during the course of hospice care. This means that hospice providers must furnish the addendum to the beneficiary or representative on or before the third day after the date of the request. For example, if a beneficiary (or representative) requests the addendum on February 22nd, then the hospice will have until February 25th to furnish the addendum, regardless of what time the addendum was requested on February 22nd.

CMS also provided some additional information in response to comments from the public:

There is nothing to preclude a hospice from furnishing an addendum through the mail. However, hospices would need to make sure the "date furnished" on the addendum is within the required timeframe (3 or 5 days, depending upon when the request was made).

The effective date for these changes is October 1, 2021.

CMS will post an updated model election statement addendum on the Hospice Webpage (as of this writing the model statement had not yet been posted)

CMS notes a number of other issues raised that were outside the scope of the rule may be considered in future rulemaking, including the late penalty, ABN and expansion of the addendum, signatures, exceptional circumstances, and educating hospice providers. They specifically note that they understand the possibility of conflating the differences between the ABN and the hospice election statement addendum.

Hospice CoP Waivers Made Permanent

As proposed, CMS is finalizing two regulatory changes that were implemented as waivers under section 1135 during the COVID-19 public health emergency:

CMS is revising the hospice aide competency standard at § 418.76(c)(1) to permit skills competencies to be assessed by observing an aide performing the skill with either a patient or a pseudo-patient as part of a simulation. These changes will allow hospices to utilize pseudo-patients, such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient. The definitions are as follows:

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

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

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

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

Updates to the Hospice Quality Reporting Program

NAHC takes this opportunity to remind hospice providers that the Annual Payment Update (APU) penalty for not participating in the HQRP increases from 2% to 4% beginning FY2024; however, it is the calendar year (CY) 2022 quality submissions that impact the FY2024 APU. Hospices will want to ensure they are meeting the CY2022 Hospice Item Set (HIS) and CAHPS Hospice Survey submission requirements. For more information on these requirements, see the CMS Hospice Quality Reporting Program webpage.

With this final rule CMS is modifying the HQRP by removing the seven "Hospice Item Set process measures" from the HQRP and adding the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI). The HIS-Comprehensive Assessment Measure will remain. These changes result in the total HQRP measures for FY022 going down to four measures with two of these measures being claim-based measures.

Although the seven individual HIS process measures are removed from the HQRP, it does not change the requirement to submit the HIS admission assessment as the data from the seven process measures is needed to calculate the Comprehensive Assessment measure. The seven HIS process measures being removed will remain in the confidential quality measure (QM) Reports which are available to hospices.

The Hospice Care Index (HCI), a "claims-based index measure", will be publicly reported no earlier than May 2022. The HCI is a single measure comprising ten indicators calculated from Medicare claims data. The index design of the HCI simultaneously monitors the following ten indicators:

Continuous Home Care (CHC) or General Inpatient (GIP) Provided

- Gaps in Nursing Visits
- Early Live Discharges
- Late Live Discharges
- Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission (Burdensome Transitions Type I)
- Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital (Burdensome Transitions Type II)
- Per-beneficiary Medicare Spending
- Nurse Care Minutes per Routine Home Care (RHC) Day
- Skilled Nursing Minutes on Weekends
- Visits Near Death

The HCI adds information to the HQRP that was either directly recommended for CMS to publicly report by the HHS Office of the Inspector General (OIG) and the Medicare Payment Advisory Commission (MedPAC) or identified as areas for improvement during CMS' information gathering activities. NAHC

and other industry stakeholders expressed concerns about the HCI and some of these indicators to CMS and requested clarification of the indicator calculations. In the final rule CMS provides this clarification and additional detail about the indicators and the calculation of the HCI composite score.

A hospice is awarded a point for meeting each criterion for each of the 10 indicators. The sum of the points earned from meeting the criterion of each indictor results in the hospice's HCI score, with 10 as

the highest possible score. CMS states that the ten indicators, aggregated into a single HCI score, convey a broad overview of the quality of the provision of hospice care services and validates well with CAHPS Willingness to Recommend and Rating of this Hospice. The HCI is a composite that can only be calculated using all 10 indicators combined. Detailed information on each of the ten HCI indicators and a HCI scoring example can be found in the Appendix.

During measure testing, CMS observed that hospices achieved scores between three and ten. In testing, 37.1 percent of hospices scored ten out of ten, 30.4 percent scored nine out of ten, 17.9 percent scored eight out of ten, 9.6 percent scored seven out of ten, and 5.0 percent scored six or lower.

Hospices will receive their HCI performance information in confidential QM reports available in CASPER (or its successor). The confidential QM report will include claims-based measure scores, including agency and national rates and will also include results of the individual indicators used to calculate the single HCI score, and provide details on the indicators and HCI overall score to support hospices in interpreting the information. However, the HCI score on Care Compare will be the composite score. The HCI indicators will be available to the public in the Provider Data Catalog at https://data.cms.gov/provider-data/topics/hospice-care.

CMS responded to many of the concerns about the HCI expressed by NAHC and other stakeholders. Overall, CMS believes:

The HCI indicators are not just program integrity indicators, they are also quality indicators because the OIG, MedPAC, peer reviewed articles and the Technical Expert Panel (TEP) identified them as quality issues.

The HCI should be reported publicly, as opposed to being shared with hospices through reports such as the PEPPER (Program for Evaluating Payment Patterns Electronic Report), so that beneficiaries, caregivers, or other stakeholders may consider as they make choices about end-of-life care.

That visits refused by patients/caregivers would not have an outsized effect on any hospice's performance on this measure.

That the HCI does adequately differentiate hospice performance and positively correlates with the CAHPS Hospice Survey responses.

In response to concerns about how the HCI may impact small and/or rural hospices, CMS stated it will monitor the HCI score trends to identify whether any regional or size-based variations suggest a need for measure revision.

In addition to details of the HCI, CMS responded to commenters questions about the HVLDL that centered around calculation of the measure. NAHC addressed these in an April 2021 NAHC Report article.

For both of the claim-based measures, CMS commented that it recognizes that claims data do not include all the disciplines involved in the delivery of hospice care, such as the frequency and length of chaplain visits. However, it also believes that claims data that currently exists still provides new and useful information not currently available to patients, families, and caregivers with the existing HQRP measures. If additional data points become available, CMS will consider modifying the measure in light of the new data.

CMS intends to continue to develop future claim-based measures and is considering developing hybrid quality measures that would be calculated using claims, assessment (HOPE), or other data sources and sought comment in these areas. Many comments were received for future quality measures such as measures related to postmortem service, plan of care goal achievement, spiritual care, psychosocial care, veteran services, volunteer activities, visit activity at the time of admission, change of level of care, change of physical location, safety culture, and workforce engagement, and patient and family care needs.

Relative to the CAHPS Hospice Survey star rating, as stated in the proposed rule, CMS will display this rating no sooner than FY 2022 and will do so utilizing the methodology proposed. Prior to finalizing a timeline, CMS will provide multiple opportunities to share information and receive comments from stakeholders. This could include a special open door forum or other venues for interaction. Hospices and stakeholders will be pleased to know that CMS stated it will take into consideration the option of starting the stars display when all data will be after the COVID-exempted quarters. CMS will also explore the feasibility of conducting a dry run of the star ratings with reporting to hospices via preview reports, which would occur prior to the start of the public display of the ratings. This was one of the recommendations NAHC made.

In other hospice quality areas, the proposal to revise § 418.312(b) Submission of Hospice Quality Reporting Program data to revise regulations to include administrative data as part of the HQRP, and correct technical errors identified in the FY 2016 and 2019 Hospice Wage Index and Payment Rate Update final rules was finalized. Also finalized was the plan to continue public reporting for the CAHPS Hospice Survey of the most recent 8 quarters of data, excluding the exempted quarters: Quarter 1 and Quarter 2 of CY 2020 (due to the Public Health Emergency (PHE)). The volume-based exemption and the newness exemption for the CAHPS Hospice Survey were extended through all future years, as proposed.

The PHE is impacting the public reporting of HQRP data and CMS finalized its proposal that, in the COVID-19 PHE, it will use 3 quarters of HIS data for the final affected refresh, the February 2022 public reporting refresh of Care Compare for the Hospice setting. Using 3 quarters of data for the February 2022 refresh would allow CMS to begin displaying Q3 2020, Q4 2020, and Q1 2021 data in February 2022, rather than continue displaying November 2020 data (Q1 2019 through Q4 2019). Updating the data in February 2022 by more than a year relative to the November 2020 freeze data would assist consumers by providing more relevant quality data and allow hospices to demonstrate more recent performance. CMS will continue to post national averages for quality measures and will add state scores for all measures no earlier than May 2022. This information will help consumers understand relative performance at national and local levels in light of the COVID-19 PHE. CMS will publicly report claims data for care delivered in Q4 2019 and Q3 2020 onward but will not publicly report claims data for care delivered Q1 and Q2 of 2020. Therefore, the two claim-based measures, HVLDL and HCI, if released in May 2022 would begin with FY2021 (Q1, Q2, and Q3 2021 and Q4 2020). The next four quarters would be Q3 2020 and Q2, Q3, and Q4 of 2019—that is, past quarters adding up to eight quarters but omitting Q1 and Q2 of 2020, which were exempt from quality reporting.

As part of the proposed rule CMS requested information on Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Post-Acute Care Quality Reporting Programs and requested information on closing the health equity gap in post-acute care quality reporting programs. Many thoughtful comments were received, and CMS responded with appreciation for the comments

and interest. As CMS stated in the proposed rule, it is not responding to specific comments submitted for these requests for information. It will continue to take all concerns, comments, and suggestions into account as it consider future changes to quality reporting.

If you have any questions regarding the FY2021 Hospice Wage Index Rule, please contact Anne Shelley at ashelley@leadingageohio.org.