

## Hospice FY2022 Wage Index Rule Summary

April 9<sup>th</sup>, 2021



The proposed Hospice FY2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements was released on the Federal Register public inspection site on April 8<sup>th</sup>, is scheduled for publication in the Federal Register on April 14<sup>th</sup>, and comments are due on June 7<sup>th</sup>. This summary is not exhaustive; we encourage members to read the whole rule. The page numbers referenced in this summary refer to the [public inspection copy of the rule linked here](#).

LeadingAge will convening members in the coming weeks to discuss the rule and formulate comments. Please contact Mollie with any questions at [mgurian@leadingage.org](mailto:mgurian@leadingage.org).

### FEEDBACK REGARDING HOSPICE UTILIZATION AND SPENDING (PGS. 17-34)

#### *CMS Analysis*

CMS looks at hospice utilization and spending patterns in the rule. Their analyses look at utilization by level of care, lengths of stay, live discharge rates, and skilled visits in the last days of life. The rule also looks at non-hospice spending during a hospice election. The analyses are based on FY2019 data; the impacts of the COVID-19 emergency are still being analyzed. Some topline findings include:

- Medicare hospice expenditures have grown from \$3.5 billion in FY2001 to \$20 billion in FY2019 with the average spending per beneficiary increasing from \$11,158 to \$12,687 from FY2010 to FY2019.
- The number of beneficiaries receiving hospice has grown from 584,438 in FY2001 to over 1.6 million in FY 2019
- Expenditures are expected to increase by approximately 7.6% annually
- The top principal diagnoses remain neurological and organ-based failure conditions
- Most care remains at the routine home care level of care and that has not changed much between FY2010 and FY2019. Of interest is that the amount of GIP care was 2.1% of care in FY2010 and that dropped to 1.2% of care in FY2019. Correspondingly, the percent of payment to hospice at the GIP level of care was 8.5% in FY2010 and 4.9% in FY2019. Therefore, despite the rebalancing, there is still a drop in the use of GIP. The same pattern holds true for CHC though it is a smaller proportion of both care and payments.
- Medicare paid over \$1 billion in non-hospice spending during a hospice election in FY2019 for items in Part A, B, and D.
- Medicare payments for non-hospice Part A and B items and services received by hospice beneficiaries during a hospice election increased from \$583 million in FY2016 to \$692 million in FY2019 which is an increase of 18.7%.

Please see the rule for more analysis including on the service intensity adjustment, live discharges, and more details on the categories noted above.

*Feedback requested*

CMS is soliciting comments on all aspects of the analysis in the proposed rule regarding hospice utilization and spending patterns. In particular, they are soliciting feedback on the following questions related to hospice utilization and spending:

- 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?
- What other factors not covered in the analysis may influence whether or how certain services are furnished to hospice beneficiaries.
- CMS is also interested in stakeholder feedback as to whether the hospice election statement addendum has changed the way hospices make care decisions and how the addendum is used to prompt discussions with beneficiaries and non-hospice providers to ensure that the care needs of beneficiaries who have elected the hospice benefit are met.

**UPDATING PROPOSED LABOR SHARES (PG. 34-40)**

The rule proposes to rebase and revise the labor shares for all levels of care using Medicare Cost Report (MCR) data for freestanding hospices. CMS proposes to continue to establish separate labor shares for all levels of care and base them on the calculated compensation cost weights for each level of care from the 2018 MCR data.

CMS is proposing to derive a compensation cost for each level of care that consists of 5 major components: 1) direct patient care salaries and contract labor costs; 2) direct patient care benefits costs; 3) other patient care salaries, 4) overhead salaries, and 5) overhead benefits costs. For each level of care, CMS is proposing to use the same methodology to derive the components except for components 1 and 3, they will use the MCR worksheet that is specific to that level of care.

The rule cite exactly which pieces of the MCR will be used for each component and the methodology for deriving compensation costs is detailed on pgs 38-4 of the rule.

Based on the methodology proposed by CMS, the proposed and current labor shares by level of care would be; they invite comments on the proposed methodology:

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

**PROPOSED FY2022 HOSPICE PAYMENT RATES**

Taking into account the proposed changes for the labor share, the FY2022 proposed payment rates are (please see the rule for the SIA budget neutrality factor, the wage index standardization factor, and labor share standardization factor). These rates are for hospices that submit their required quality data.

Code	Description	FY2021 Payment Rates	FY 2022 Proposed Hospice Payment update	FY 2022 Proposed Hospice Payment Rates
651	RHC Days 1-60	\$199.25	x1.023	\$203.81
651	RHC days 61+	\$157.49	x1.023	\$161.02
652	CHC Full Rate = 24 hrs of care	\$1,432.41 (\$59.68 per hour)	x1.023	\$1,456.79 (\$61.07 per hour)
655	IRC	\$461.09	x1.023	\$474.43
656	GIP	\$1,045.66	x1.023	\$1,070.35

The proposed hospice cap for FY2022 cap year is \$31,389.66, which is equal to the FY 2021 cap amount (\$30,683.93) updated by the proposed FY 2022 hospice payment update percentage of 2.3 percent

The proposed hospice wage index applicable for FY 2022 (October 1, 2021 through September 30, 2022) is available on CMS' website at: <https://www.cms.gov/Center/Provider-Type/Hospice-Center>

#### ELECTION STATEMENT ADDENDUM CLARIFICATIONS (PGS 49-56)

In response to questions from stakeholders, CMS provided and is seeking comment on the following proposed clarifications and conforming regulation text changes:

- *Timing of addendum:* CMS is proposing to allow the hospice to furnish the addendum within 5 days from the date of a beneficiary or representative request, if the request is within 5 days from the date of a hospice election. For example, if the patient elects hospice on December 1st and requests the addendum on December 3rd, the hospice would have until December 8th to furnish the addendum.
- *Timing of signature:* CMS proposes to clarify in regulation that the “date furnished” must be within the required timeframe (that is, 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date. At § 418.24(c)(10), CMS proposes that the hospice would include the “date furnished” in the patient’s medical record and on the addendum itself.
- *Refusal to sign:* CMS clarifies in the rule that if a patient or representative refuses to sign the addendum, the hospice must document clearly in the medical record (and on the addendum itself) the reason the addendum is not signed in order to mitigate a claims denial for this condition for payment. In such a case, although the beneficiary has refused to sign the addendum, the “date furnished” must still be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative request, depending on when such request was made), and noted in the chart and on the addendum itself.
- *Non-Hospice Provider Request for Addendum and Signature:* CMS is proposing to clarify in regulation that if a non-hospice provider requests the addendum, rather than the beneficiary or representative, the non-hospice provider is not required to sign the addendum

- *Regulation Conformity:* CMS is proposing conforming regulations text changes at § 418.24(c) in alignment with sub-regulatory guidance indicating that hospices have “3 days,” rather than “72 hours” to meet the requirement when a patient requests the addendum during the course of a hospice election.

#### **HOSPICE WAIVERS MADE PERMANENT CONDITIONS OF PARTICIPATION (PGS 56-59)**

CMS proposes to:

- *Using pseudo-patients:* Make permanent the ability for hospices to use pseudo-patients and simulations to assess hospice aide competency. These proposed changes would permit hospices to utilize pseudo-patients, defined a person trained in a role-play situation or a computer based mannequin instead of actual patients in the competency of hospice aides for those tasks that must be observed being performed on a patient.
- *Targeting corrections of deficiencies:* CMS is also proposing to amend the requirement at 418.76(h)(1)(iii) to specify that if an area of concern is verified by a hospice during an onsite 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 allow for the hospice to focus on the hospice aides’ specific deficient and related skill(s) rather than completing another full competency exam.

#### **HOSPICE QUALITY REPORTING PROGRAM (HQRP) (PGS. 59-129)**

*Proposal to remove the seven “Hospice Item Set process measures” from the HQRP beginning FY2022 (pgs 66-69)*

The following measures were put in place in FY2014 to comprise the Hospice Item Set: 1) NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen; 2) NQF #1634 Pain Screening; 3) NQF #1637 Pain Assessment; 4) NQF #1638 Dyspnea Treatment; 5) NQF #1639 Dyspnea Screening; 6) NQF #1641 Treatment Preferences ; and 7) NQF #1647 Beliefs/Values Addressed (if desired by the patient). CMS weighed these measures against the factors for measure removal established in the FY2016 rule and their analysis found that there was a more broadly applicable measure for the particular topic available. This measure is NQF #3235: HIS Comprehensive Assessment Measure. CMS asserts that the HIS comprehensive assessment measure “all or nothing” criterion that requires hospices to perform all seven care measure processes to receive credit encourages higher performance and therefore higher quality.

CMS does not propose to display the seven components separately. They do not propose any changes to the HIS comprehensive assessment measure. They also are not proposing any changes to the requirement to submit the HIS admission assessment.

CMS is seeking comments on the removal of the seven individual HIS process measures from the HQRP and no longer reporting them as individual measures on Care Compare starting in FY2022 (no earlier than May 2022).

*Proposal to add a “claims-based index measure,” the Hospice Care Index (pgs. 69-95)*

CMS is proposing to a new hospice quality measure, the Hospice Care Index (HCI). [We commented on the HCI as part of our participation in NQF's Measure Application Partnership.](#)

The HCI is a single measure comprising ten indicators calculated from Medicare claims data. The index design of the HCI simultaneously monitors all ten indicators. Collectively these indicators represent different aspects of hospice service and thereby characterize hospices comprehensively, rather than on just a single care dimension. Each indicator equally affects the single HCI score, reflecting the equal importance of each aspect of care delivered from admission to discharge. A hospice is awarded a point for meeting each criterion for each of the 10 indicators. The sum of the points earned from meeting the criterion of each indicator results in the hospice's HCI score, with 10 as the highest hospice score. The ten indicators, aggregated into a single HCI score, are intended to convey a broad overview of the quality of hospice care provision and validates well with CAHPS Willingness to Recommend and Rating of this Hospice.

The indicators are:

- Indicator One: Continuous Home Care (CHC) or General Inpatient (GIP) Provided
- Indicator Two: Gaps in Nursing Visits
- Indicator Three: Early Live Discharges
- Indicator Four: Late Live Discharges
- Indicator Five: Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission
- Indicator Six: Burdensome Transitions (Type 2) - Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital
- Indicator Seven: Per-beneficiary Medicare Spending
- Indicator Eight: Nurse Care Minutes per Routine Home Care (RHC) Day
- Indicator Nine: Skilled Nursing Minutes on Weekends
- Indicator Ten: Visits Near Death

Please consult the rule for indicator specifications and a sample scoring of the measure. CMS is accepting comments on the measure.

#### *Update on HOPE and future Quality Measures (pgs. 97-102)*

CMS includes an update on the HOPE tool and on their future work in measurement development, including links to recent TEP reports on pages 97-102. They are asking for comment on the HOPE and some new candidates for claims based quality measures discussed by the TEPs. They are also considering hybrid quality measures in the future that would combine claims, assessment (eg. HOPE), or other data sources. They are seeking public comment on quality measure concepts and considerations for the development of hybrid measures.

#### *Proposal to Add CAHPS Hospice Survey Star Ratings to Public Reporting (pgs. 105-107)*

CMS is proposing to introduce star ratings for public reporting of CAHPS survey results on the Care Compare (or successor website) no sooner than FY2022. We propose that the calculation and display of the CAHPS Hospice Survey Star Ratings be similar to that of other CAHPS Star Ratings programs such as Hospital CAHPS and Home Health CAHPS. The stars would range from one star (worst) to five stars

(best). We propose that the stars be calculated based on “top-box” scores for each of the eight CAHPS Hospice Survey measures. Specifically, individual-level responses to survey items would be scored such that the most favorable response is scored as 100 and all other responses are scored as 0. A hospice-level score for a given survey item would then be calculated as the average of the individual-level responses, with adjustment for differences in case mix and mode of survey administration.

For a measure composed of multiple items, the hospice-level measure score is the average of the hospice-level scores for each item within the measure. Similar to other CAHPS programs, CMS proposes that the cut-points used to determine the stars be constructed using statistical clustering procedures (more information on this is contained in the rule) that minimize the score differences within a star category and maximize the differences across star categories.

CMS proposes to calculate a summary or overall CAHPS Hospice Survey Star Rating by averaging the Star Ratings across the 8 measures, with a weight of ½ for Rating of the Hospice, a weight of ½ for Willingness to Recommend the Hospice, and a weight of 1 for each of the other measures, and then rounding to a whole number. They propose that only the overall Star Rating be publicly reported and that hospices must have a minimum of 75 completed surveys in order to be assigned a Star Rating

*Proposal to Publicly Report the Hospice Care Index and “Hospice Visits in the Last Days of Life” Claims-based Measures*

CMS proposes to publicly report the HCI and HVLDL beginning no earlier than May 2022 using FY2021 Medicare hospice claims data, and to include it in the Preview Reports no sooner than the May 2022 refresh.

*Proposal Regarding Data Collection and Reporting during a Public Health Emergency (pgs 110-121)*

CMS proposes that, in the COVID-19 PHE, CMS would use 3 quarters of HIS data for the final affected refresh, the February 2022 public reporting refresh of Care Compare for the Hospice setting. Using 3 quarters of data for the February 2022 refresh would allow 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). CMS believes that updating the data in February 2022 by more than a year relative to the November 2020 freeze data would assist consumers by providing more relevant quality data and allow hospices to demonstrate more recent performance. CMS seek public comment on this proposal to use 3 quarters of HIS data for the February 2022 public reporting refresh. They also seek comment on their CAHPS solution where they propose to publicly report the most-recently available 8 quarters of CAHPS data starting with the February 2022 refresh and going through the May 2023 refresh on Care Compare because they cannot publicly report Q1 2020 and Q2 2020 data due to the COVID-19 PHE.

*Proposals for calculating and publicly reporting “claims-based measure” as part of the HQRP (pgs 121-125)*

CMS presents four proposals related to calculating and reporting claims based measures, with specific application to HVLDL and HCI:

- CMS proposes to extract claims data to calculate claims-based measures at least 90 days after the last discharge date in the applicable period, which they will use for quality measure calculations and public reporting on Care Compare.
- CMS proposes that they will update the claims-based measures used for the HQRP annually;
- CMS proposes that they will calculate claims-based measure scores based on one or more years of data.
- CMS proposes using 2 years of data to publicly report HCI and HVLDL in 2022

CMS provides extensive background on their reasoning for these timeframes and asks for comments on all four proposals.

### HOME HEALTH QUALITY REPORTING DISPLAY SCHEDULE (PGS.128-142)

CMS included this Home Health proposal in this rule because they plan to resume public reporting for the HH QRP with the January 2022 refresh of Care Compare. In order to accommodate the exception of 2020 Q1 and Q2 data, they are proposing to resume public reporting using 3 out of 4 quarters of data for the January 2022 refresh. This would allow them to begin displaying recent data in January 2022 rather than displaying October 202 data for longer. In order to finalize this proposal in time to release the required preview report related to the refresh, the proposal needs to be finalized by October 2021 and the home health payment rule likely will not meet that timeline.

CMS is proposing to modify our public display schedule to display fewer quarters of data than what they previously finalized for certain HH QRP measures for the January 2022 refreshes. They are proposing to go with a COVID-19 Affected Reporting (CAR) Scenario as opposed to a Standard Reporting Scenario for the refresh; what measures would have looked like under each scenario is displayed in the rule text. They are seeking comment on CAR scenario and are planning to use it for refreshes from January 2022 through July 2024.

### REQUESTS FOR INFORMATION

*Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Post-Acute Care Quality Reporting Programs – Request for Information (pg 142-147)*

In addition to providing background on interoperability and digital quality measurement goals and work to date, CMS is seeking input on the following steps that would enable transformation of CMS' quality measurement enterprise to be fully digital:

- What EHR/IT systems do you use and do you participate in a health information exchange (HIE)?
- How do you currently share information with other providers and are there specific industry best practices for integrating SDOH screening into EHR's?
- What ways could we incentivize or reward innovative uses of health information technology (IT) that could reduce burden for post-acute care settings, including but not limited to hospices?
- What additional resources or tools would post-acute care settings, including but not limited to hospices and health IT vendors find helpful to support testing, implementation, collection, and reporting of all measures using FHIR standards via secure APIs to reinforce the sharing of patient health information between care settings?

- Would vendors, including those that service post-acute care settings, including but not limited to hospices, be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would align standards for quality measure data collection across care settings to improve care coordination, such as sharing patient data via secure FHIR API as the basis for calculating and reporting digital measures?
- What could be the potential use of FHIR dQMs that could be adopted across all QRPs? We plan to continue working with other agencies and stakeholders to coordinate and to inform our transformation to dQMs leveraging health IT standards.

*Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs – Request for Information (pages 147-154)*

Specifically, CMS is asking for public comment on the following:

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

For both of these RFIS, CMS will not be responding to specific comments submitted in response to this Request for Information in the FY 2022 Hospice Wage Index final rule, but intend to use this input to inform future policy development.