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FY 2024 Hospice Payment Rate Updated Proposed Rule

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On April 4, 2023, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule for FY 2024 addressing the Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician and Provider Enrollment Requirements. The deadline for submitting comments to this proposed rule is May 30, 2023.

This article provides a summary of the key proposed changes, including the following:

- Updates to the hospice wage index, payment rates, and aggregate cap amount for FY 2024
- Changes to the regulations in anticipation of the expiration of the COVID-19 Public Health Emergency (PHE)
- Updates to the Hospice Quality Reporting Program, the Hospice Outcome and Patient Evaluation tool, Health Equity and future quality measures, the Consumer Assessment of Healthcare Providers and Systems, and the Hospice Survey Mode Experiment
- Changes that would require hospice certifying physicians to be enrolled in Medicare or validly opted out of Medicare

The proposed rule also solicits requests for information on: (1) the provision of higher levels of hospice care; (2) spending patterns for non-hospice services provided during the election of the hospice benefit; (3) ownership transparency; (4) equipping patients and caregivers with information to inform hospice selection; and (5) ways to examine health equity under the hospice benefit.

Hospice Utilization and Spending Patterns

In the proposed rule, CMS discusses its statistical analysis of hospice utilization and spending patterns. Hospice care continues to become a more common option for care for the terminally ill among Medicare beneficiaries, in that the number of beneficiaries receiving hospice services has increased by more than 1 million beneficiaries between FY 2003 and FY 2022, yielding a $17 billion increase in Medicare hospice expenditure during the same period. CMS expects aggregate hospice expenditures to continue to increase by approximately 9.1 percent annually.

For-profit and non-profit hospices continue to have distinctly different profiles. For-profit hospices greatly outnumber non-profit hospices: approximately 74 percent of hospices were for-profit in FY 2022, while approximately 16 percent were non-profit organizations. For-profit hospices continued to be the most commonly used option, providing approximately 64 percent of all hospice days, while non-profit hospices provided approximately 27 percent of all hospice days during the fiscal year.

As in the past, routine home care (RHC) continues to represent the highest percentage of total hospice days and of total hospice payments. There remains a high percentage of hospices that provide little to no continuous

home care (CHC), inpatient respite care (IRC), or general inpatient care (GIP), despite CMS' rebasing of payment rates in FY 2020, in part to encourage the increased availability of higher levels of care by better-aligning hospice payment with the costs of providing care. One notable trend among hospices relates to the differences in the levels of care offered by for-profit and non-profit hospices. For example, for-profit hospices make up 82.9 percent of the hospices that do not provide GIP and 84.3 percent of the hospices that do not provide IRC in a given fiscal year. However, for-profit hospices are relatively more likely to provide CHC in a given fiscal year, comprising 68.5 percent of the hospices that provided CHC.

Additionally, live discharges are also more common among for-profit hospices, with for-profit hospices having approximately 21 to 22 percent of live discharges per year, while non-profit hospices have a live discharge rate of approximately 12 percent. Of the live discharges in FY 2022, revocations and instances in which the beneficiary can no longer be certified as terminally ill were the two most common reasons for live discharge, at virtually identical rates of 35 percent because of revocations and 36 percent because of a change from terminal illness. For-profit hospices also had, on average, 60 percent higher non-hospice spending per day compared to beneficiaries under non-profit hospice care.

Requests for Information

In the proposed rule, CMS is seeking Requests for Information (RFI) from providers on various issues in an effort to improve the hospice benefit with the goal of addressing issues related to quality care, improved access, and value. CMS is requesting information that is not otherwise available to it on claims assessments or through other public data sources.

The information sought pertains to an analysis conducted by CMS revealing a decrease in the percentages of hospice billing for higher levels of care, specifically CHC, IRC, and GIP, despite substantial payment increases beginning in FY 2020. Notably, the payment increases were designed to help provide hospices with greater access to facilities and contractors that provide CHC, IRC, and GIP. CMS suggests that the decreases in the use of higher levels of care and limited higher-cost palliative treatments, such as dialysis, blood transfusions, chemotherapy, and radiation, indicate that there may be barriers to care for certain beneficiaries with more complex palliative needs. Notably, patients do not forfeit their ability to receive these higher-cost palliative treatments by virtue of electing the hospice benefit. Rather, these treatments may be covered under the hospice benefit if they would be beneficial for symptom control.

In sum, CMS hopes to gain information that will enable it to improve access and provide more value within the hospice benefit.

Summary of Proposed Changes to Hospice Wage Index, Payment Rates, and Aggregate Cap Amount for FY 2024

CMS proposes to use the FY 2024 hospital wage index data to calculate the FY 2024 hospice wage index. This methodology uses the hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2019, and before October 1, 2020 (FY 2020 cost report data).

The proposed FY 2024 hospice wage index would not consider any geographic reclassification of hospitals and would include a five percent cap on wage index decreases. This is consistent with CMS's permanent approach to ease yearly changes in providers' wage indexes by placing a five percent cap on all wage index decreases in future years regardless of the reason for the decrease as announced in the FY 2023 hospice final rule. This change allows the geographic index to not be less than 95 percent of a provider's wage index as calculated in the prior FY.

The proposed Hospice Payment Update Percentage for FY 2024 would be updated using the methodology for the proposed inpatient hospital market basket update of three percent. This market basket update is reduced

by a productivity adjustment mandated by the Affordable Care Act which is currently estimated to be a 0.2 percentage point for FY 2024. This means that the proposed hospice payment update for FY 2024 would be 2.8 percent. Hospices that do not submit quality data as required by the Hospice Quality Reporting Program (and discussed below) would receive a cumulative payment update percentage for FY 2024 of minus 1.2 percent. The proposed FY 2024 Hospice Payment Rates update the payment rates for the four categories of hospice care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP).

The proposed rule implements a proposed hospice cap amount for FY 2024 of $33,396.55 which is equal to the FY 2023 cap amount ($32,486.92) and updated by the proposed FY 2024 hospice payment update percentage of 2.8 percent. The longstanding policy behind the hospice cap amount is to ensure that hospice spending is not more than conventional care spending at the end of life and maintain hospice as a home-based benefit.

Proposed Changes to Reimbursement in Anticipation of the Expiration of the PHE

In the proposed rule for FY 2024, CMS proposes to extend the use of telecommunications to conduct the face-to-face encounter during the PHE "or through December 31, 2024, whichever is later." Although the PHE is set to end on May 11, 2023, hospice providers would be able to continue to be reimbursed for the face-to-face encounter through December 31, 2024, if the proposed rule is made final. This proposed change would align with the Consolidated Appropriations Act of 2023, which extended the regulatory flexibility of hospice providers to use telehealth for face-to-face encounters for the recertification of the hospice benefit via telehealth through the end of CY 2024.

This regulatory flexibility became effective in March 2020, when CMS amended hospice coverage requirements at 42 CFR 418.204 to permit reimbursement for hospice services provided via telehealth during the PHE if it was feasible and appropriate to do so to ensure that Medicare patients could continue to receive services that were reasonable and necessary for the palliation and management of a patient's terminal illness and related conditions. The amendments specified that "the use of such technology in furnishing services must be included on the plan of care, meet the requirements at § 418.56, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care."

Pursuant to this amendment, CMS reimbursed hospice providers for certain telehealth services provided to hospice patients during the PHE, including the face-to-face encounter that is required for all patients whose stay across all hospices is anticipated to reach the third benefit period. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to the third benefit period recertification, and every benefit period recertification thereafter, to obtain clinical findings and determine continued eligibility for hospice care.

Proposed Changes to Medicare Provider Enrollment for Physicians who Order or Certify Hospice Services

CMS is proposing to require all physicians who order or certify hospice services for Medicare beneficiaries to be enrolled in Medicare or validly opted out of Medicare as a requisite to pay for hospice services. This proposed change would add certain language to the regulatory text at 42 CFR 424.507(b), which contains the Conditions of Payment for items and services ordered for Medicare beneficiaries. In addition, CMS would require that each hospice certification required under 42 CFR 418.22(c) be performed by physicians enrolled in Medicare or validly opted out of Medicare. CMS is proposing these changes due to hospice integrity concerns that have arisen in recent years and as discussed by the Office of Inspector General (OIG) in its July 2018 study titled "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity" (OEI-02-16-00570). CMS believes that requiring physicians to be enrolled in Medicare or validly opted out will enable it to more closely vet physicians and prevent fraud.

Proposals and Updates to the Hospice Quality Reporting Program

The Hospice Quality Reporting Program (HQRP) sets forth specific reporting requirements for the Hospice Item Set, administrative data, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) hospice survey. Compliance with these reporting obligations is critical for hospices as noncompliance results in a reduction to the market basket update of two percentage points in FY 2024 and four percentage points in FY 2025 and all subsequent years. CMS reports that approximately 18 percent of Medicare-certified hospices are found noncompliant with these reporting requirements and subject to the payment reduction.

In late spring 2023, CMS intends to provide additional information regarding the Hospice Outcomes and Patient Evaluation (HOPE) Tool testing results on the HQRP website. CMS plans to use the field test results to create a final version of HOPE that will be proposed for full implementation in future rulemaking. Once HOPE is implemented, CMS intends to develop several quality measures based on the information that HOPE collects. At present, CMS is considering at least two HOPE-based process and outcome quality measures: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact.

In the FY 2023 Hospice Payment Rate Update proposed rule, CMS included an RFI on hospices' current health equity activities and future approaches to advancing health equity in hospice. Specifically, the FY 2023 RFI considered developing a structural composite quality measure for hospices.

In 2022, a CMS contractor initiated a technical expert panel (TEP) to review potential quality measure development for home health and hospice. Specifically, the TEP assessed the facial validity and feasibility of the potential structural measure. The TEP also provided input on possible confidential feedback report options to be used for monitoring health equity. TEP members had the opportunity to provide ideas for additional health equity measure concepts or approaches to addressing health equity in hospice and home health settings. CMS plans to release a summary of the Home Health & Hospice Health Equity TEP meetings and final TEP recommendations later this calendar year.

Additionally, to further the goals of the CMS National Quality Strategy 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. According to CMS in its proposed rule, this "Universal Foundation" of quality measure will focus provider attention; reduce burden; identify disparities in care; prioritize development of inter-operable, digital quality measures; allow for cross-comparisons across programs; and help identify measurement gaps.

Finally, one consideration CMS is pursuing around expanded health equity measurement is including social determinants of health in its quality measures and data stratification. By looking at measure results for different populations separately, CMS and providers can see how care outcomes may differ between certain patient populations in a way that would not be apparent from an overall score (i.e., a score averaged over all beneficiaries). CMS is also taking into consideration the health equity measures used in other health care provider settings through social determinants of health assessment items including Post-Acute Care Settings like home health and skilled nursing.

Codifying Hospice Data Submission

CMS proposes to codify data completeness thresholds at § 418.312(j)(1) for measuring data collected using the Hospice Item Set (HIS) or a successor instrument. Under this section, they propose to codify requirements that hospices must meet or exceed a data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (i.e., a patient's admission or discharge) and submit the data through CMS's designated data submission systems. This threshold would apply to all HIS or successor instrument-based measures and data elements adopted into HQRP.

CMS also proposes to codify § 418.312(j)(2) that a hospice must meet or exceed this threshold to avoid receiving a four percentage point reduction to its annual payment update for a given FY as codified at § 418.306(b)(2).

If you have any questions related to this alert, please contact any member of Baker Donelson's Long Term Care Team.