CMS' Proposed Hospice FY2025 Payment Rule: Implications for Agencies and the Hospice Community

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Agenda

- FY2025 Proposed Payments/Aggregate Cap/Wage Index
- Labor Market Geographical Changes – proposed updates
- RFI on Expensive Palliative Treatments/Payment
- What's Missing? Program Integrity
- Hospice Quality Reporting Program
- Clarifying Regulation Text Changes

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CMS Delayed in Posting Utilization Data

- "*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 webpage****, which can be found at https://www.cms.gov/medicare/payment/fee-for-serviceproviders/hospice.*"

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FY2025 PROPOSED PAYMENTS/ AGGREGATE CAP/ WAGE INDEX

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FY2025 Rate Update

- Payment rate update of 2.6% (~$705 million more overall from FY 2024).
- Corresponding increase in hospice cap amount to $34,364.85.
- Hospices that fail to meet quality reporting requirements will be penalized with a 4.0% reduction.
  - 2.6% increase minus 4% penalty = - 1.4% reduction.

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FY2025 Proposed Payments – Annual Payment Update

	FY2024 Final Update	FY2025 Proposed Update
Hospital Market Basket Update	3.3%	3.0%
Productivity Adjustment	0.2%	0.4%
Annual Payment Update	3.1%	**2.6%**

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FY2025 Proposed Payments – Routine Home Care (RHC) Tiers

	FY2024 Payment Rates	Adjustments	Proposed FY2025 Payment Rates	Proposed FY2025 Payment Rates with HQRP penalty
Routine Home Care (days 1-60)	$218.33	*SIA budget neutrality factor *Wage index standardization factor	$223.83	$215.10
Routine Home Care (days 61+)	$172.35		$176.39	$169.51

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FY2025 Proposed Payments – Continuous Home Care (CHC), Inpatient Respite Care (IRC) & General Inpatient Care (GIP Home Care (RHC) Tiers

	FY2024 Payment Rates	Adjustments	Proposed FY2025 Payment Rates	Proposed FY2025 Payment Rates with HQRP penalty
Continuous Home Care = 24 hours	$1,565.46 ($65.23/hour)	*Wage index standardization factor	$1,610.34 ($67.10/hour)	$1,547.56 (64.48 per hour)
Inpatient Respite Care	$507.71		$518.15	$497.95
General Inpatient Care	$1,145.31		$1,166.98	$1,121.48

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Wage Index Updates

- Starting in FY25: Proposal to adopt **new labor market geographic delineations as a result of the 2020 Census** (*CMS did this last in FY2016 rule based on 2010 census*)
- Will change payment for some hospices (some will see higher rates, some lower, but overall change is budget-neutral across the program)
  - ~54% of Core Based Statistical Areas (CBSAs) projected to see decrease or no change in wage index
  - ~46% of CBSAs projected to see increase in wage index
- Reminder: the appropriate wage index value is applied to the labor portion of the hospice payment rate based on:
  - Where the beneficiary resides when receiving **RHC or CHC** (what Core-Based Statistical Area [CBSA] they are in)
  - Where the facility is located for beneficiaries receiving **GIP or IRC** (what Core-Based Statistical Area [CBSA] it is in)

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Wage Index Updates

- **5% cap on wage index losses** is an important "stop-loss" policy to mitigate very large yr-to-yr swings in payment based on geography
  - CMS: "a *permanent 5% 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% of its wage index calculated in the prior FY*." (finalized in FY2023 rule)
- But….if you do have a 5% (or close to it) decrease in wage index, that could have significant impact on payment.
- See NAHC Report proposed rule summary for links to tables on impacted counties/CBSAs

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Request for Information (RFI): "High Intensity Palliative Care Services" Payment & Operation

- CMS acknowledging (helpfully) that it is difficult for most hospices to cover these kinds of treatments (ex. palliative dialysis, palliative chemotherapy, palliative radiations, palliative blood transfusions), which can result in access challenges for patients needing/wanting them.
- Builds on RFI from FY2024 proposed rule (driven in part by advocacy and congressional interest):
  - "*commenters stated that 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*"
- New wrinkle in this RFI is asking explicitly about payment and financial burdens associated with these interventions
- Potential signal of CMS' interest in hospice benefit payment reform

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Request for Information (RFI): "High Intensity Palliative Care Services" Payment & Operation

1. ***What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?***
2. ***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)?***
3. ***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?***
4. ***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?)***
5. ***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?***
6. ***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?***

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Rule Contains No Program Integrity Updates

- Absence of any new data, commentary, or provisions related to hospice program integrity is notable given focus of last year+ and ongoing challenges with fraud, waste, and abuse in parts of the country.
  - 421 new hospices added in 2023, almost 70% of which were in the four "hotspot" states of CA, TX, AZ, & NV
  - New hospices enrolled in 2023 & 2024 at specific locations that are known fraud centers (ex. building in Los Angeles that houses over 100 hospices)
- Additional targeted actions needed to ensure integrity:
  - Put a temporary targeted Medicare enrollment moratorium in place for new hospices in high-fraud areas
  - Authorize CMS to target hospices that meet certain red-flag criteria. Such "red flags" could include hospices that don't bill Medicare, many hospices co-located at a single address, and individual hospice administrators overseeing many hospices simultaneously

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Hospice Quality Reporting Program

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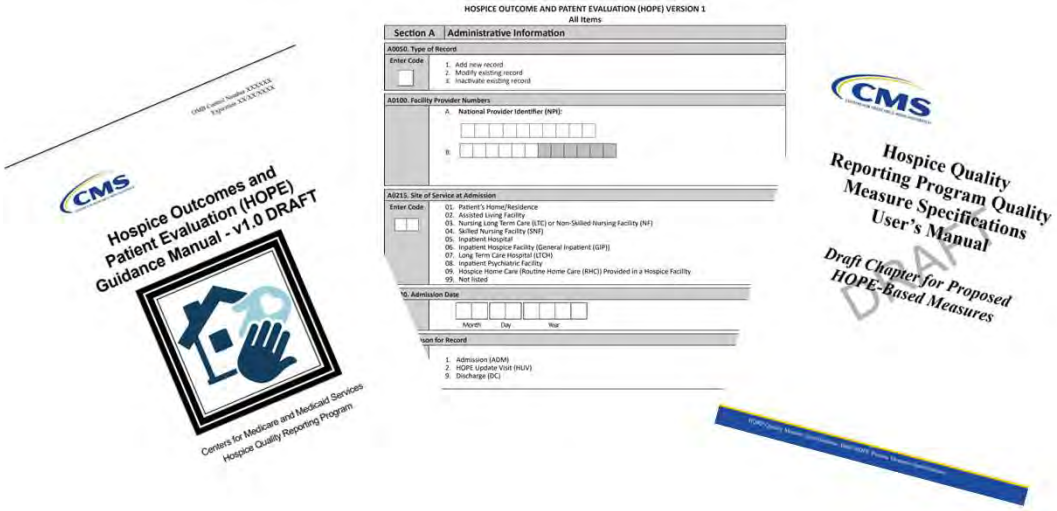

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HOPE

- Hospice Outcomes & Patient Evaluation (HOPE)
- Proposed implementation date: **on or after October 1, 2025**

- Standardized patient level data collection tool
- Replaces Hospice Item Set (HIS)
- CMS HOPE webpage

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HOPE

- Provide data for HQRP quality measures
- Inform future payment refinement
- Support proposed quality measures
- Contributes to the patient's plan of care through providing patient data throughout the hospice stay
  - Improved practice and
  - Care quality

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HOPE

- Patient level data collection tool
  - All patients
  - Regardless of payor source
- Timepoints
  - Admission
  - Hospice Update Visit
    - Days 6-15
    - Days 16-30
    - Symptom Reassessment (SRA) may be required
  - Discharge

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HOPE

- Includes some data elements for certain post-acute care providers
  - IMPACT Act of 2014
  - CMS considering tracking key demographic and social risk factor items that apply to hospice

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Future HOPE-based Quality Measures

- Future quality measures
- Timely Reassessment of Pain Impact
  - Percentage of patients who receive a pain impact reassessment within 2 calendar days of when pain impact was determined to be moderate or severe
- Timely Reassessment of Non-Pain Symptom Impact
  - Percentage of patients who receive a non-pain symptoms impact reassessment within 2 calendar days of when non-pain symptom impact was initially assessed to be moderate or severe

2021 Technical Expert Panel (TEP) Summary Reports

2021 Information Gathering Report

HOPE Development and Testing Report

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HOPE

Public reporting
- On or after CY2027
- CMS must establish reliability and validity
- At least four quarters of data analyzed

Example:
Implementation October 1, 2025
October – December 2025 NOT ELIGIBLE
All four quarters CY2026 analyzed in CY2027

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CAHPS Hospice Survey

- Mode experiment 2021
  - Removal of one survey item regarding confusing or contradictory information from the Hospice Team Communication measure;
  - Replacement of the multi-item Getting Hospice Care Training measure with a new, one-item summary measure;
  - Addition of a new, two-item Care Preferences measure;
  - Simplified wording to component items in the Hospice Team Communication, Getting Timely Care, and Treating Family Member with Respect measures.
- Measures Under Consideration (MUC) 2023
- Possibly part of future rulemaking

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CAHPS Hospice Survey

- Proposed revised survey and administrative protocol
- To be implemented: **beginning with January 2025 decedents**
- Public reporting of measures
  - Care Compare refresh November 2027
  - Scores calculated using data from Q1 2025 through Q4 2026
  - Measure scores and Star Ratings may be introduced in different quarters

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CAHPS Hospice Survey

- Removal of three nursing home items and an item about moving the family member that are not included in scored measures.
- Removal of one survey item regarding confusing or contradictory information from the Hospice Team Communication measure
- Replacement of the multi-item Getting Hospice Care Training measure 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.

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CAHPS Hospice Survey

- Add web-mail mode option
- Add pre-notification letter
- Extend field period to 49 days

Hospice Survey

Please answer the survey questions about the care the patient listed on the survey cover letter received from this hospice:

[NAME OF HOSPICE]

All of the questions in this survey will ask about experiences with this hospice.

If you want to know more about this survey, please call XXX-XXX-XXXX. All calls to this number are free.

OMB # XXXX-XXXX
Expires DATE

Who Should Fill Out the Survey?

- The person in your household who knows the most about the hospice care received by the patient listed on the survey cover letter.

How to Fill Out the Survey

- Please use a dark colored pen.
- Please put an X inside the square by your answer, like this:

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Request For Information

- Regarding Future HQRP Social Determinants of Health (SDOH) Items
- Domains that align across post-acute care (PAC) and hospice care settings
  - housing instability,
  - food insecurity,
  - utility challenges, and
  - barriers to transportation access
- Health equity focus

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Clarifying Regulatory Text Changes

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Medical Director

- Medical Director Condition of Participation (CoP) at § 418.102
  - Discrepancy with payment requirements for the "certification of the terminal illness" and the "admission to hospice care" at § 418.22 and § 418.25, respectively
  - Proposed revision to text of the regulations to include the
    - medical director, or physician designee if the medical director is not available, or physician member of the IDG may review the clinical information and certify and recertify the terminal illness.

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Medicare Election Statement & NOE

- Conflation of “election statement” and “Notice of Election”
- Two separate and distinct documents
- Proposing to title § 418.24(b) as “Election Statement” and would include the title “Notice of Election” at § 418.24(e)
- Notice of Election
  - must be filed with the hospice Medicare Administrative Contractor (MAC) within five calendar days after the effective date of hospice election.
- Election statement
  - a beneficiary (or their representative) must file an ‘‘election statement’’
  - § 418.24(b)

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Resources

FY2025 Hospice Proposed Rule

https://www.govinfo.gov/content/pkg/FR-2024-04-04/pdf/2024-06921.pdf

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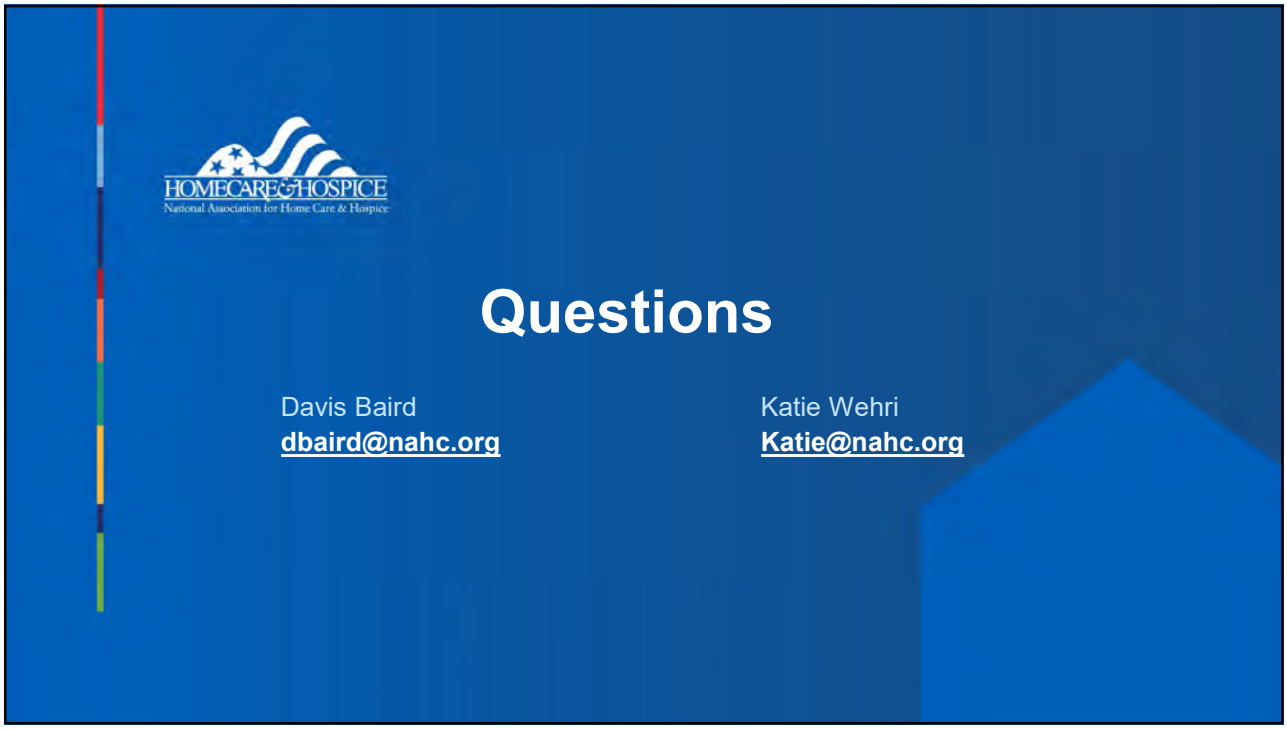
HOMECARE & HOSPICE
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