CMS Releases FY2025 Hospice Wage Index and Payment Rate Update Final Rule

July 30, 2024

On July 30, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program final rule, which updates payment rates, the wage index, and the cap amount for FY 2025, and makes several changes to the Hospice Quality Reporting Program, CAHPS® Hospice Survey, and clarificatory changes to the Medicare hospice regulations and conditions of participation. The final rule also implements the Hospice Outcomes and Patient Evaluation (HOPE) data collection instrument beginning on or after October 1, 2025.

Here are the highlights:

- **Payment Rate Update.** CMS is finalizing a **2.9%** increase for FY 2025, which reflects a 3.4% market basket percentage increase, decreased by a 0.5 percentage point productivity adjustment.
- **Hospice Cap Amount.** CMS finalizes a hospice cap amount for the FY 2025 cap year of **$34,465.34**, which is equal to the FY 2024 cap amount ($33,494.01) updated by the final FY 2025 hospice payment update percentage of 2.9%.
- **Change to Statistical Areas**. CMS finalizes its proposal to incorporate the Office of Management and Budget (OMB) statistical area delineations based on the 2020 Decennial Census. This will result in changes to the wage index rate for some hospices. The 5% cap on wage index decreases year over year will be applied to these changes.

- **Hospice Outcomes and Patient Evaluation (HOPE) Data Collection Instrument.** CMS will begin collecting HOPE patient-level data collection data effective October 1, 2025, which would replace the existing Hospice Item Set (HIS).
- **Quality Measures**. CMS finalizes two new quality process measures based on HOPE data, including 'Timely Reassessment of Pain Impact' and 'Timely Reassessment of Non-Pain Symptom Impact.' Public reporting of these measures would begin no earlier than November 2027 (FY2028).
- **CAHPS® Hospice Survey**. CMS is finalizing several changes to the CAHPS® Hospice Survey, including the addition of an optional web-mail mode survey option, beginning with April 2025 decedents.
- **Clarifying Regulatory Text Revisions.** CMS finalizes its proposal to align Medicare hospice payment and CoP requirements by clarifying that the medical director, physician designee if the medical director is unavailable, or a physician member of the hospice interdisciplinary group may review patient clinical information and certify a patient's terminal illness. CMS also finalizes its proposal to clarify regulations to better distinguish between the election statement and Notice of Election. In addition, CMS finalized a technical edit regarding marriage and family therapists.
- **Requests for Information.** CMS thanked commenters for their insights and recommendations in response to the two requests for information included in the proposed rule, including the potential implementation of a separate payment mechanism to account for high-intensity palliative care services under the hospice benefit, including chemotherapy, radiation, and transfusions, and future Hospice Quality Reporting Program social determinants of health items.

The overall impact of the rule is an estimated $790 million in increased hospice payments.

Based on an initial review, NAHC-NHPCO Alliance's interim Co-Chief Executive Officers Bill Dombi and Ben Marcantonio commented, "The Final FY 2025 Rule issued by the Centers for Medicare and Medicaid Services (CMS) on Hospice payment rates and multiple other modifications affecting hospice operations is well within our expectations. It includes a combination of an increase in the payment rates and aggregate annual cap from the 2.6% proposal to 2.9%, significant wage index revisions, and mostly favorable modifications and clarifications in technical conditions of participation and payment. Additionally, the most notable element is the requirement that the long-awaited HOPE quality measures instrument will take effect on October 1, 2025. While the hospice community has long

supported modernization of patient quality assessment instruments and data reporting, it is concerning that CMS requires a difficult timetable for compliance with no financial support for the significant costs brought by the initiation of the HOPE instrument. We look forward to a positive partnership with CMS to address these concerns."

The final rule and its wage index tables can be found here: https://www.cms.gov/medicare/payment/fee-service-providers/hospice/hospice-regulations-and-notices/cms-1810-f.

The NAHC-NHPCO Alliance is in the process of reviewing the final rule and will provide additional analysis soon. The Alliance is also hosting two joint webinars on the topic.

Hospice Wage Index and Payment Rate Update

For FY 2025, CMS finalizes a rate increase of **2.9%** for hospices who meet quality reporting requirements**.** CMS finalizes a hospice cap amount of **$34,465.34** for FY 2025.

Payment Rates for Hospices Who Submit Required Quality Data

Code	Description	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2025 Hospice Payment Update	Final FY 2025 Payment Rates	FY 2024 Payment Rates
651	Routine Home Care (days 1-60)	1.0009	0.9983	1.029	**$224.62**	$218.33
651	Routine Home Care (days 61+)	1.0000	0.9975	1.029	**$176.92**	$172.35
652	Continuous Home Care (24 hours)	N/A	1.0026	1.029	**$1,618.59** ($67.44/hour)	$1,565.4

655	Inpatient Respite Care	N/A	0.9947	1.029	**$518.78**	$507.71
656	General Inpatient Care	N/A	0.9931	1.029	**$1,170.04**	$1,145.3

Please note: *Payment rates for hospice providers NOT complying with the hospice quality reporting requirements will be four percentage points lower than the values referenced in the above table.*

While we appreciate the 0.3% increase from the proposed rule to the final rule, a 2.9% update does not adequately reflect the increased costs and resource intensity resulting from ongoing workforce shortages and inflationary pressures. As the seminal NORC analysis showed, utilization of the hospice benefit saves the overall Medicare program billions of dollars a year – CMS needs to recognize this dynamic value and provide appropriate and sufficient payment updates that encourage and support greater access to high-quality hospice care.

In our comments on the proposed rule, the NAHC-NHPCO Alliance also highlighted that there have been three years of under forecasted payment rate updates for hospices, and requested a one-time retrospective adjustment using special exceptions and adjustment authority to rectify the significant forecast error since 2021. Once again, and unfortunately, CMS responded to these valid concerns by stating that "*There is currently no mechanism to adjust for market basket forecast error in the hospice payment update*."

Statistical Area Delineations

CMS finalizes its proposal to adopt the most recent OMB statistical area delineations, which revise the existing core-based statistical areas (CBSA) based on data collected during the 2020 Decennial Census. The changes to the CBSAs impact the hospice wage index. As a reminder, the appropriate wage index value gets 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.

Hospices negatively affected by the change to their geographic wage index as a result of this rule will only experience a maximum 5% reduction to their 2024 wage index, as there is

a 5 percent cap on any decrease to the wage index from the prior year. This permanent cap, finalized in the FY 2023 Hospice Final Rule, prevents a geographic area's wage index from falling below 95% of its wage index calculated in the prior FY. While acknowledging that many hospices may see decreases to their wage index as a result of this rule, CMS states that "*We continue to believe that the finalized 5-percent cap policy provides an adequate safeguard against any significant payment reductions, allows for sufficient time to make operational changes for future fiscal years, and provides a reasonable balance between mitigating some short-term instability in hospice payments and improving the accuracy of the payment adjustment for differences in area wage levels*." Pages 41-42 of the unpublished rule.

In the final rule, CMS states that 28 commenters provided feedback on the updated labor market delineations and resulting hospice wage index impacts. NAHC and NHPCO both reiterated numerous concerns associated with utilizing hospital cost report data to determine the hospice wage index in their comment letters. CMS states that weighing-in on changes to the hospice wage index methodology were outside the scope of this rule, but that they would "*consider these comments in the future if CMS does consider changes to this methodology.*"

Wage Index Transition Code:

Due to the way that CMS will calculate the 5% 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% 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% 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**. CMS is finalizing as proposed 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% 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.

The counties that will require a transition code and the corresponding 50XXX codes are shown in Table 8.

Urban Counties That Will Become Rural:

Under the revised OMB statistical area delineations, a total of 53 counties (and county equivalents) that are currently considered urban will be considered rural beginning in FY 2025. Table 3 in the final rule lists the 53 counties that will become rural based on the revised OMB delineations.

Rural Counties That Will Become Urban:

Under the revised OMB statistical area delineations, a total of 54 counties (and county equivalents) that are currently located in rural areas will be considered urban areas under the revised OMB delineations beginning in FY 2025. Table 4 in the rule lists the 54 counties that will become urban based on the revised OMB delineations.

Urban Counties That Will 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 will shift from one urban CBSA to a new or existing urban CBSA under the revised OMB delineations. In other cases, applying the new OMB delineations involves a change only in CBSA name or number, while the CBSA will continue to encompass the same constituent counties. Table 5 in the rule lists CBSAs that will change in name and/or CBSA number only, but the constituent counties will not change (except in instances where an urban county became rural, or a rural county became urban).

In some cases, all the urban counties from a FY 2024 CBSA will be moved and subsumed by another CBSA in FY 2025. Table 6 in the rule lists the CBSAs that will be subsumed by another CBSA.

In other cases, some counties will shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. In another type of change, some CBSAs have counties that will split off to become part of or to form entirely new labor market areas. In some cases, a CBSA will lose counties to another existing CBSA. Table 7 in the rule lists the 73 urban counties that would move from one urban CBSA to a new or modified urban CBSA under the revised OMB delineations.

HOPE Data Collection Instrument

The Hospice Outcomes and Patient Evaluation (HOPE) instrument is a hospice patient-level item set to be used by all hospices to collect and submit standardized data on each

patient admitted to hospice. CMS finalized its proposal for hospices to collect and report HOPE data on or after October 1, 2025. This supports public reporting of two HOPE-based quality measures – Timely Reassessment of Pain Impact and Timely Reassessment of Non-Pain Impact – in FY 2028. Following HOPE's implementation, CMS will require hospices to complete and submit HOPE for all patients, regardless of payer or patient age. After HOPE's implementation, hospices will no longer be required to collect or submit the Hospice Item Set (HIS).

CMS finalized its decision that the data from the first quarter Q4 CY 2025, with HOPE data collection beginning in October 2025, will not be used for assessing validity and reliability of the quality measures even though it also stated that, typically, the first two quarters of data after adoption of a standardized data collection instrument are reflective of the learning curve. CMS will assess the quality and completeness of the data near the end of Q4 2025 before publicly 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. CMS stated that it will inform the public of the decisions about whether to report some or all the quality measures publicly based on the findings of analysis of the CY 2026 data.

Upcoming provider trainings related to HOPE v1.0 will be posted on the CMS HQRP website on the Announcement and Spotlight page and announced during Open Door Forums. These trainings will help providers understand the requirements necessary to be successful with the HQRP, including how data collected via the new HOPE tool is submitted for quality measures and contributes to compliance with the HQRP.

CMS will provide the HOPE technical data specifications for software developers and vendors on the CMS website. CMS also reiterated that software developers and vendors should not wait for final technical data specifications to begin development of their own products. There will be a call with software developers and vendors after the draft specifications are posted, during which CMS will respond to questions, comments, and suggestions.

Once HOPE is implemented and HIS is phased out, CMS will require hospices to submit 90% of all required HOPE records within 30 days of the event or completion date. Hospices that fail to submit required HOPE assessments for at least 90% of their patients will be subject to a 4% reduction in their annual payment update beginning with the Annual Payment Update (APU) for FY2027 (FY2025 data).

Hospice Quality Reporting Program Measures

CMS finalizes its proposal to implement two process quality measures based on HOPE data collection no sooner than FY 2028 for public reporting (November 2027). These measures are *Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Impact*. Providers will have an opportunity to preview the data prior to public reporting.

Timely Reassessment of Pain Impact will determine how many patients assessed with moderate or severe pain impact were reassessed by the hospice within two calendar days. Pain symptom severity and impact will be determined based on patient responses to the pain symptom impact data elements within HOPE. Timely Reassessment of Non-Pain Symptom Impact will determine how many patients assessed with moderate or severe non-pain symptom impact were reassessed by the hospice within two calendar days. Non-pain symptom impact and severity will be determined based on patient responses to the HOPE data elements related to shortness of breath, anxiety, nausea, vomiting, diarrhea, constipation, and agitation.

Patients will be excluded from measure denominators if they die or are discharged before the two-day reassessment time frame, if the patient/caregiver refuses a reassessment visit, if the hospice was unable to contact the patient/caregiver to perform a reassessment visit, if the patient traveled outside the service area, or if the patient was in the ER or hospital during the two-day reassessment time frame.

Both process measures based on HOPE data will be calculated using assessments collected at admission or at symptom follow-up visits. CMS proposed and finalizes that only in-person visits would count for the collection of data for these proposed measures—that is, telehealth visits and telecommunication phone calls will not count for a reassessment. CMS states that it believes the reassessment visit should be performed by clinicians and clarified that these visits can be completed by either RNs or LPNs/LVNs. However, CMS adds that it will continue to monitor the provision and burden of in-person HOPE follow-up visits after HOPE implementation and evaluate whether revisions to the HOPE administration requirements are necessary. If modifications to the HOPE instrument are required, they will be proposed in future rulemaking.

CMS plans to provide additional information on the measures. Until then, hospices and stakeholders can view the draft HQRP QM Manual Chapter for HOPE Process Measures as well as the HOPE Guidance Manual on the CMS HOPE webpage and the PRA package that accompanied the FY 2025 proposed rule which can be accessed on the CMS PRA Listing webpage.

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 Payment 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

FY 2025 Hospice Wage Index Final Rule, Table 15.

CAHPS® Hospice Survey

CMS is finalizing the CAHPS® Hospice Survey questionnaire as proposed, including the addition of a new web-mail mode, to be effective with April 2025 decedents. This is a change from CMS's proposal to begin with January 2025 decedents, in response to concerns the NAHC-NHPCO Alliance and other stakeholders raised about implementation challenges. These revisions are based in part on the results of a mode experiment conducted with 56 large hospices in 2021, which tested a web-mail mode, among other revisions. In this final rule, CMS updates the hospice CAHPS survey to include the removal of specific items related to care received in nursing homes, including questions about training, care coordination, and the communication of different information. CMS is replacing the multi-item "Getting Hospice Care Training" measure with a simplified summary measure that asks if the hospice team taught caregivers how to care for their family members.

CMS also removes several items, such as those regarding mobility training, confusing or contradictory information about a family member's condition, and several items from the Getting Hospice Care Training measure. CMS adds two new items to calculate the new Care Preferences measures, including whether the hospice team listened to what mattered most to the hospice decedent or family, and provided care that respected the patient's wishes.

Additionally, CMS simplifies the survey wording across multiple measures, including hospice team communication, getting timely care, and treating family members with respect. **CMS will implement an optional new web-mail mode survey, featuring an**

initial email invitation followed by a mail survey for non-responders. To improve response rates, a pre-notification letter will be sent a week before the survey**. Lastly, CMS will extend the field response period from 42 to 49 days.** These changes are effective beginning with April 2025 decedents. CMS indicates training materials will be made available in early fall 2024. CMS has a draft updated survey instrument available for survey vendor review on the CAHPS Hospice Survey webpage at https://www.hospicecahpssurvey.org/globalassets/hospice-cahps4/surveyinstruments/revised_cahps-hospice-survey_for-website.pdf.

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

MEASURE	**Item(s) in Current Measure**	**Item(s) in 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 durin 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 t understand?”

	“While your family member was in hospice care, how often did the hospice team keep you informed about your family member’s condition?”	“How often did the hospice team kee you informed 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 liste carefully to you when you talked with them about problems with your famil 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 trea your family member with dignity and respect?”
	“While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member?”	“How often did you feel that the hospice team really cared about 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 ge 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 ge the help needed for trouble with constipation?”
	“How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness?”	“How often did your family member ge the help they needed from the hospic team for feelings of anxiety or sadness?”
	“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 spiritual beliefs did you get from the hospice team?”	“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 you get from the hospice team?”
Getting Emotional and Religious Support	“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	N/A (removed from revised survey)

	effects of pain medicine with you or your family member?”	
	“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 your family member?”	N/A (removed from revised survey)
	“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 t[o] 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?”
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 o 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?”

FY 2025 Hospice Wage Index Final Rule, Table 14.

In response to feedback raised by the NAHC-NHPCO Alliance along with other stakeholders, CMS is evaluating the best option to implement the revised OMB “Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity” for collecting race and ethnicity across all CAHPS surveys. CMS will alert hospices and survey vendors when implementation plans are finalized.

To determine the impact of CAHPS® survey changes on public reporting, CMS considered the nature of the measure changes. Since Care Preferences would be a new measure and Getting Hospice Care Training is undergoing substantiative revisions, CMS will treat both measures as new measures and wait until eight complete quarters of data are available for both measures prior to public reporting.

CMS anticipates these measures would first be included in the February 2028 Care Compare refresh, with scores calculated from Q2 2025 through Q1 2027. This is a slight change from CMS’s proposal to begin as early as the November 2027 refresh (with scores calculated using data from Q1 2025 through Q4 2026). CMS indicates these changes may be introduced in different quarters for Star Ratings and measure scores given the calculation of measure scores quarterly and Star Ratings every other quarter. During the

interim period, CMS will make measure scores available to hospices in their Provider Preview Reports once the survey completion threshold has been met.

CMS indicates that changes to the *Hospice Team Communication* measure are non-substantive and that the measure should continue to be publicly reported and included in Star Ratings during the transition between current and new surveys. During the transition period, publicly reported scores and Star Ratings would be calculated by combining scores from quarters using the current and new surveys.

In consideration of the above, CMS finalizes its proposal that the Family Caregiver Survey Rating Summary Star Rating will be based on seven measures rather than the current eight (i.e. all existing measures minus *Getting Hospice Care Training*) during the interim period until a full eight quarters of data are available for the *Getting Hospice Care Training* measure. Once eight quarters of data are available for *Care Preferences* and *Getting Hospice Care Training*, the summary Star Rating will be based on nine measures moving forward, instead of the current eight.

CMS is reiterating its position that CAHPS changes will not have any substantive impact on the Hospice Special Focus Program (SFP). In the final rule, CMS states, "[a]ll changes to the survey instrument and administration procedures will be introduced at the same time for all hospices, so it should affect their scores equally; therefore, changes are not expected to differentially impact any hospices' performance on the SFP algorithm." Page 135 of the unpublished rule. CMS reaffirms this position in the final rule fact sheet, which states in part, "[t]his final rule includes changes to the Overall Rating of this Hospice measure that are non-substantive and will not impact the SFP algorithm." The NAHC-NHPCO Alliance is concerned that CMS has not provided any data or analysis in support of assertion and remains committed to the implementation of an accurate SFP algorithm that will effectively identify hospices most in need of oversight.

Clarifying Regulatory Text Changes

Medical Director Condition of Participation

CMS finalizes its proposal to align Medicare hospice payment and condition of participation (CoP) requirements by clarifying that the medical director, physician designee if the medical director is unavailable, or a physician member of the hospice interdisciplinary group may review patient clinical information and certify a patient's terminal illness. This is in response to discrepancies between the Medical Director Condition of Participation (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. CMS also modifies medical director introductory language at § 418.102 to replace “physician designated by” with “physician designee.”

CMS indicates this change does not reflect a change in policy, but rather is intended to promote clarity and consistency.

Election Statement and Notice of Election

To clearly delineate the differences between the election statement and the Notice of Election (NOE), CMS finalizes its proposal to reorganize the regulations to clearly describe their functions at 42 CFR § 418.24. CMS does not consider this reorganization a change in policy, but rather a clarification regarding requirements for the election statement and NOE.

Hospice Marriage and Family Therapist Technical Edit

In the CY 2024 Physician Fee Schedule rule finalized on November 16, 2023, CMS incorrectly finalized regulations using the term “marriage and family counselor” at 42 CFR § 418.144(b)(9). The agency is finalizing a technical edit to update the language to “marriage and family therapist.”

CMS Responds to Request for Information Feedback

CMS addresses feedback in response to two RFIs in the proposed rule.

Potential implementation of a separate payment mechanism for high-intensity palliative care services

CMS issued an RFI in the proposed rule to gather more information from stakeholders about the idea of and considerations around potential payment mechanisms for “high-intensity” palliative services for hospice patients (ex. palliative dialysis for patients with ESRD; palliative radiation for patients with cancer or symptom-producing tumors; etc.). CMS believes that patients with conditions that could benefit from these kinds of services may underutilize hospice.

CMS summarized the responses to the RFI and thanked commenters for taking the time to provide recommendations. No next steps or direct responses from CMS were provided but stated additional comments can be sent to hospicepolicy@cms.hhs.gov.

Members can find the NAHC and NHPCO responses to these RFI questions HERE (NAHC) and HERE (NHPCO).

Potential Hospice Quality Reporting Program social determinants of health changes

CMS summarized the responses to the RFI and thanked commenters for taking the time to provide recommendations. No next steps or direct responses from CMS were provided.

The NAHC-NHPCO Alliance will continue engaging with CMS on these and other issues.

The NAHC-NHPCO Alliance is planning webinars addressing this final rule. Additional details and registration information are forthcoming.