

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS-1675-P]

RIN 0938-AT00

Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2018. Additionally, this rule proposes changes to the hospice quality reporting program, including proposing new quality measures, soliciting feedback on an enhanced data collection instrument, and describing plans to publicly display quality measures and other hospice data.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 26, 2017.

ADDRESSES: In commenting, please refer to file code CMS-1675-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1675-P, P.O. Box 8010, Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1675-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Debra Dean-Whittaker, (410) 786-0848 for questions regarding the CAHPS® Hospice Survey.

Cindy Massuda, (410) 786-0652 for questions regarding the hospice quality reporting program.

For general questions about hospice payment policy, please send your inquiry via email to: hospicepolicy@cms.hhs.gov.

SUPPLEMENTARY INFORMATION: Wage index addenda will be available only through the internet on our Web site at: (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html>.)

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as

they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

Table of Contents

I. Executive Summary	
A. Purpose	
B. Summary of the Major Provisions	
C. Summary of Impacts	
II. Background	
A. Hospice Care	
B. History of the Medicare Hospice Benefit	
C. Services Covered by the Medicare Hospice Benefit	
D. Medicare Payment for Hospice Care	
1. Omnibus Budget Reconciliation Act of 1989	
2. Balanced Budget Act of 1997	
3. FY 1998 Hospice Wage Index Final Rule	
4. FY 2010 Hospice Wage Index Final Rule	
5. The Affordable Care Act	
6. FY 2012 Hospice Wage Index Final Rule	
7. FY 2015 Hospice Wage Index and Payment Rate Update Final Rule	
8. IMPACT Act of 2014	
9. FY 2016 Hospice Wage Index and Payment Rate Update Final Rule	
10. FY 2017 Hospice Wage Index and Payment Rate Update Final Rule	
E. Trends in Medicare Hospice Utilization	
III. Provisions of the Proposed Rule	
A. Monitoring for Potential Impacts—Affordable Care Act Hospice Reform	
1. Hospice Payment Reform: Research and Analyses	
a. Length of Stay and Live Discharges	
b. Skilled Visits in the Last Days of Life	
c. Non-Hospice Spending	
2. Initial Analysis of Revised Hospice Cost Report Data	
a. Background	
b. Methodology	
c. Overall Payments and Costs and Costs by Level of Care	
B. Proposed FY 2018 Hospice Wage Index and Rate Update	
1. Proposed FY 2018 Hospice Wage Index	
2. Proposed FY 2018 Hospice Payment Update Percentage	
3. Proposed FY 2018 Hospice Payment Rates	
4. Hospice Cap Amount for FY 2018	
C. Discussion and Solicitation of Comments Regarding Sources of Clinical Information for Certifying Terminal Illness	
D. Proposed Updates to the Hospice Quality Reporting Program	
1. Background and Statutory Authority	
2. General Considerations Used for Selection of Quality Measures for the HQRP	
3. Policy for Retention of HQRP Measures Adopted for Previous Payment Determination	
4. Policy for Adopting Changes to Previously Adopted Measures	

5. Previously Adopted Quality Measures for FY 2018 Payment Determination and Future Years
 6. Proposed Removal of Previously Adopted Measures
 7. Measure Concepts Under Consideration for Future Years
 8. Form, Manner, and Timing of Quality Data Submission
 9. Previously Adopted APU Determination and Compliance Criteria for the HQRP
 10. HQRP Submission Exemption and Extension Requirements for the FY 2019 Payment Determination and Subsequent Years
 11. CAHPS® Hospice Survey Participation Requirements for the FY 2020 APU and Subsequent Years
 12. HQRP Reconsideration and Appeals Procedures for the FY 2018 Payment Determination and Subsequent Years
 13. Confidential Feedback Reports
 14. Public Display of Quality Measures and Other Hospice Data for the HQRP
- IV. Collection of Information Requirements
- A. Hospice Item Set
 - B. Summary of CAHPS® Hospice Survey Information Collection Requirements (OMB Control Number 0938–1257)
- V. Response to Comments
- VI. Request for Information on Medicare Flexibilities and Efficiencies
- VII. Regulatory Impact Analysis
- A. Statement of Need
 - B. Overall Impacts
 - C. Anticipated Effects
 - D. Detailed Economic Analysis
 - E. Alternatives Considered
 - F. Accounting Statement
 - G. Reducing Regulation and Controlling Regulatory Costs
 - H. Conclusion

Acronyms

Because of the many terms to which we refer by acronym in this proposed rule, we are listing the acronyms used and their corresponding meanings in alphabetical order:

- APU Annual Payment Update
 ASPE Assistant Secretary of Planning and Evaluation
 BBA Balanced Budget Act of 1997
 BIPA Benefits Improvement and Protection Act of 2000
 BNAF Budget Neutrality Adjustment Factor
 BLS Bureau of Labor Statistics
 CAHPS® Consumer Assessment of Healthcare Providers and Systems
 CASPER Certification and Survey Provider Enhanced Reports
 CBSA Core-Based Statistical Area
 CCN CMS Certification Number
 CCW Chronic Conditions Data Warehouse
 CFR Code of Federal Regulations
 CHC Continuous Home Care
 CHF Congestive Heart Failure
 CMS Centers for Medicare & Medicaid Services
 COPD Chronic Obstructive Pulmonary Disease
 CoPs Conditions of Participation
 CPI-U Consumer Price Index-Urban Consumers
 CVA Cerebral Vascular Accident
 CWF Common Working File
 CY Calendar Year
 DME Durable Medical Equipment
 DRG Diagnostic Related Group
 FEHC Family Evaluation of Hospice Care
 FR Federal Register
 FY Fiscal Year
 GAO Government Accountability Office
 GIP General Inpatient Care
 HCFA Healthcare Financing Administration
 HHS Health and Human Services
 HIS Hospice Item Set
 HQRP Hospice Quality Reporting Program
 ICD-9-CM International Classification of Diseases, Ninth Revision, Clinical Modification
 ICD-10-CM International Classification of Diseases, Tenth Revision, Clinical Modification
 ICR Information Collection Requirement
 IDG Interdisciplinary Group
 IMPACT Act Improving Medicare Post-Acute Care Transformation Act of 2014
 IPPS Inpatient Prospective Payment System
 IRC Inpatient Respite Care
 LCD Local Coverage Determination
 MAC Medicare Administrative Contractor
 MACRA Medicare Access and CHIP Reauthorization Act of 2015
 MAP Measure Applications Partnership
 MedPAC Medicare Payment Advisory Commission
 MFP Multifactor Productivity
 MSA Metropolitan Statistical Area
 NF Long Term Care Nursing Facility
 NOE Notice of Election
 NOTR Notice of Termination/Revocation
 NP Nurse Practitioner
 NPI National Provider Identifier
 NQF National Quality Forum
 OIG Office of the Inspector General
 OACT Office of the Actuary
 OMB Office of Management and Budget
 PEPPER Program for Evaluating Payment Patterns Electronic Report
 PRRB Provider Reimbursement Review Board
 PS&R Provider Statistical and Reimbursement Report
 Pub. L. Public Law
 POC Plan of Care
 QAPI Quality Assessment and Performance Improvement
 QIO Quality Improvement Organization
 RHC Routine Home Care
 RN Registered Nurse
 SBA Small Business Administration
 SEC Securities and Exchange Commission
 SIA Service Intensity Add-on
 SNF Skilled Nursing Facility
 TEFRA Tax Equity and Fiscal Responsibility Act of 1982
 TEP Technical Expert Panel
 UHDDS Uniform Hospital Discharge Data Set
 U.S.C. United States Code

I. Executive Summary

A. Purpose

This rule proposes updates to the hospice payment rates for fiscal year (FY) 2018, as required under section 1814(i) of the Social Security Act (the

Act). This rule also discusses and solicits comments on the source of the clinical information used to certify an individual as terminally ill (that is, having a life expectancy of 6 months or less as defined in section 1861(dd)(3)(A)) as required by section 1814(a)(7)(A) of the Act. Finally, this rule also proposes new quality measures and provides an update on the hospice quality reporting program (HQRP) consistent with the requirements of section 1814(i)(5) of the Act. In accordance with section 1814(i)(5)(A) of the Act, starting in FY 2014, hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to their payments.

B. Summary of the Major Provisions

Section III.A of this proposed rule describes monitoring activities intended to identify potential impacts related to the hospice reform policies finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule and analyzes current trends in hospice utilization and expenditures. Section III.B.1 updates the hospice wage index with updated wage data and makes the application of the updated wage data budget neutral for all four levels of hospice care. In section III.B.2, we discuss the FY 2018 hospice payment update percentage of 1.0 percent. Sections III.B.3 and III.B.4 update the hospice payment rates and hospice cap amount for FY 2018 by the hospice payment update percentage discussed in section III.B.2.

In section III.C of this proposed rule, we discuss and solicit comments on the appropriate source(s) of the required clinical information for certification of a medical prognosis of a life expectancy of 6 months or less.

Finally, in section III.D of this proposed rule, we discuss updates to HQRP, including proposed changes to the CAHPS® Hospice Survey measures as well as the possibility of utilizing a new assessment instrument to collect quality data. In section III.D, we will also discuss proposed enhancements to the current Hospice Item Set (HIS) data collection instrument to be more in line with other post-acute care settings. The new data collection instrument would be a comprehensive patient assessment instrument, rather than the current chart abstraction tool. Additionally, in this section we discuss our plans for sharing HQRP data publicly later in Calendar Year (CY) 2017, as well as plans to provide public reporting via a Compare Site in CY 2017 and future years.

C. Summary of Impacts

TABLE 1—IMPACT SUMMARY TABLE

Provision description	Transfers
FY 2018 Hospice Wage Index and Payment Rate Update	The overall economic impact of this proposed rule is estimated to be an estimated \$180 million in increased payments to hospices during FY 2018.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes that the impending death of an individual, upon his or her choice, warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice is compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

Medicare regulations define “palliative care” as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (§ 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit. *See also* “Medicare and Medicaid Programs: Hospice Conditions of Participation” final rule (73 FR 32088, June 5, 2008). The goal of palliative care in hospice is to improve the quality of life of beneficiaries and their families and caregivers through early identification and management of pain and other issues associated with a life limiting condition. The hospice interdisciplinary group works with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary’s care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as

the individual approaches the end of life.

Medicare hospice care is palliative care for individuals with a prognosis of living 6 months or less if the terminal illness runs its normal course. When a beneficiary is terminally ill, many health problems are related to the underlying condition(s), as bodily systems are interdependent. In the 2008 Hospice Conditions of Participation final rule, we stated that “the [hospice] medical director must consider the primary terminal condition, related diagnoses, current subjective and objective medical findings, current medication and treatment orders, and information about unrelated conditions when considering the initial certification of the terminal illness” (73 FR 32176). As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient’s attending physician (if any) and the hospice medical director must certify that the individual is “terminally ill,” as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual’s prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. The regulations at § 418.22(b)(3) require that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

While the goal of hospice care is to allow the beneficiary to remain in his or her home, circumstances during the end-of-life may necessitate short-term inpatient admission to a hospital, skilled nursing facility (SNF), or hospice facility for necessary pain control or acute or chronic symptom management that cannot be managed in any other setting. These acute hospice care services ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home. Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the

individual can remain at home.

Continuous home care may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with our regulations at § 418.204. A minimum of 8 hours of nursing care, or nursing and aide care, must be furnished on a particular day to qualify for the continuous home care rate (§ 418.302(e)(4)).

Hospices are expected to comply with all civil rights laws, including the provision of auxiliary aids and services to ensure effective communication with patients and patient care representatives with disabilities consistent with section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Additionally, they must provide language access for such persons who are limited in English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at <http://www.hhs.gov/ocr/civilrights>.

B. History of the Medicare Hospice Benefit

Before the creation of the Medicare hospice benefit, hospice programs were originally operated by volunteers who cared for the dying. During the early development stages of the Medicare hospice benefit, hospice advocates were clear that they wanted a Medicare benefit that provided all-inclusive care for terminally-ill individuals, provided pain relief and symptom management, and offered the opportunity to die with dignity in the comfort of one’s home rather than in an institutional setting.¹ As stated in the August 22, 1983 proposed rule entitled “Medicare Program; Hospice Care” (48 FR 38146), “the hospice experience in the United States has placed emphasis on home care. It offers physician services, specialized nursing services, and other forms of care in the home to enable the terminally ill individual to remain at home in the company of family and friends as long as possible.” The concept of a beneficiary “electing” the hospice benefit and being certified as terminally ill were two key components of the legislation responsible for the creation of the Medicare Hospice

¹ Connor, Stephen. (2007). Development of Hospice and Palliative Care in the United States. OMEGA. 56(1), p. 89–99.

Benefit (section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), (Pub. L. 97–248)). Section 122 of TEFRA created the Medicare Hospice benefit, which was implemented on November 1, 1983. Under sections 1812(d) and 1861(dd) of the Act, we provide coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a Medicare-certified hospice. Our regulations at § 418.54(c) stipulate that the comprehensive hospice assessment must identify the beneficiary's physical, psychosocial, emotional, and spiritual needs related to the terminal illness and related conditions, and address those needs in order to promote the beneficiary's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors: The nature and condition causing admission (including the presence or lack of objective data and subjective complaints); complications and risk factors that affect care planning; functional status; imminence of death; and severity of symptoms (§ 418.54(c)). The Medicare hospice benefit requires the hospice to cover all reasonable and necessary palliative care related to the terminal prognosis, as well as, care for interventions to manage pain and symptoms, as described in the beneficiary's plan of care. Additionally, the hospice Conditions of Participation (CoPs) at § 418.56(c) require that the hospice must provide all reasonable and necessary services for the palliation and management of the terminal illness, related conditions, and interventions to manage pain and symptoms. Therapy and interventions must be assessed and managed in terms of providing palliation and comfort without undue symptom burden for the hospice patient or family.² In the December 16, 1983 Hospice final rule (48 FR 56010), regarding what is related versus unrelated to the terminal illness, we stated: “. . . we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case by case basis. It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients.” Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis, all conditions are considered to be related to the terminal prognosis

and the responsibility of the hospice to address and treat.

As stated in the December 16, 1983 Hospice final rule, the fundamental premise upon which the hospice benefit was designed was the “revocation” of traditional curative care and the “election” of hospice care for end-of-life symptom management and maximization of quality of life (48 FR 56008). After electing hospice care, the beneficiary typically returns home from an institutional setting or remains in the home, to be surrounded by family and friends, and to prepare emotionally and spiritually, if requested, for death while receiving expert symptom management and other supportive services. Election of hospice care also requires waiving the right to Medicare payment for curative treatment for the terminal prognosis, and instead receiving palliative care to manage pain or other symptoms.

The benefit was originally designed to cover hospice care for a finite period of time that roughly corresponded to a life expectancy of 6 months or less. Initially, beneficiaries could receive three election periods: Two 90-day periods and one 30-day period. Currently, Medicare beneficiaries can elect hospice care for two 90-day periods and an unlimited number of subsequent 60-day periods; however, at the beginning of each period, a physician must certify that the beneficiary has a life expectancy of 6 months or less if the terminal illness runs its normal course.

C. Services Covered by the Medicare Hospice Benefit

One requirement for coverage under the Medicare Hospice benefit is that hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. Section 1861(dd)(1) of the Act establishes the services that are to be rendered by a Medicare-certified hospice program. These covered services include: Nursing care; physical therapy; occupational therapy; speech-language pathology therapy; medical social services; home health aide services (now called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologicals); medical appliances; counseling services (including dietary counseling); short-term inpatient care in a hospital, nursing facility, or hospice inpatient facility (including both respite care and procedures necessary for pain control and acute or chronic symptom management); continuous home care during periods of crisis, and only as necessary to maintain the terminally ill individual at home; and any other item

or service which is specified in the plan of care and for which payment may otherwise be made under Medicare, in accordance with Title XVIII of the Act.

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before care is provided by, or under arrangements made by, that hospice program and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (described in section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act). Upon the implementation of the hospice benefit, the Congress expected hospices to continue to use volunteer services, though these services are not reimbursed by Medicare (see section 1861(dd)(2)(E) of the Act). As stated in the August 22, 1983 Hospice proposed rule, the hospice interdisciplinary group should comprise paid hospice employees as well as hospice volunteers (48 FR 38149). This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end-of-life care.

Before the Medicare hospice benefit was established, the Congress requested a demonstration project to test the feasibility of covering hospice care under Medicare.³ The National Hospice Study was initiated in 1980 through a grant sponsored by the Robert Wood Johnson and John A. Hartford Foundations and CMS (then, the Health Care Financing Administration (HCFA)). The demonstration project was conducted between October 1980 and March 1983. The project summarized the hospice care philosophy and principles as the following:

- Patient and family know of the terminal condition.
- Further medical treatment and intervention are indicated only on a supportive basis.
- Pain control should be available to patients as needed to prevent rather than to just ameliorate pain.
- Interdisciplinary teamwork is essential in caring for patient and family.
- Family members and friends should be active in providing support during the death and bereavement process.

²Paolini, DO, Charlotte. (2001). Symptoms Management at End of Life. *JAOA*. 101(10). p. 609–615.

³Greer, D., Mor, V., Sherwood, S. (1983) National hospice study analysis plan. *Journal of Chronic Diseases*, Vol 36, 11, 737–780. [https://doi.org/10.1016/0021-9681\(83\)90069-3](https://doi.org/10.1016/0021-9681(83)90069-3).

- Trained volunteers should provide additional support as needed.

The cost data and the findings on what services hospices provided in the demonstration project were used to design the Medicare hospice benefit. The identified hospice services were incorporated into the service requirements under the Medicare hospice benefit. Importantly, in the August 22, 1983 Hospice proposed rule, we stated “the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices” (48 FR 38149).

D. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and our regulations in part 418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment in one of four prospectively-determined rate categories of hospice care (Routine Home Care (RHC), Continuous Home Care (CHC), inpatient respite care, and general inpatient care), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected). This per diem payment is to include all of the hospice services needed to manage the beneficiary’s care, as required by section 1861(dd)(1) of the Act. There has been little change in the hospice payment structure since the benefit’s inception. The per diem rate based on level of care was established in 1983, and this payment structure remains today with some adjustments, as noted below:

1. Omnibus Budget Reconciliation Act of 1989

Section 6005(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) amended section 1814(i)(1)(C) of the Act and provided for the following two changes in the methodology concerning updating the daily payment rates: (1) Effective January 1, 1990, the daily payment rates for RHC and other services included in hospice care were increased to equal 120 percent of the rates in effect on September 30, 1989; and (2) the daily payment rate for RHC and other services included in hospice care for fiscal years (FYs) beginning on or after October 1, 1990, were the payment rates in effect during the previous federal fiscal year increased by the hospital market basket percentage increase.

2. Balanced Budget Act of 1997

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were updated by a factor equal to the hospital market basket percentage increase, minus 1 percentage point. Payment rates for FYs from 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs will be the hospital market basket percentage increase for the FY. The Act requires us to use the inpatient hospital market basket to determine hospice payment rates.

3. FY 1998 Hospice Wage Index Final Rule

In the August 8, 1997 FY 1998 Hospice Wage Index final rule (62 FR 42860), we implemented a new methodology for calculating the hospice wage index based on the recommendations of a negotiated rulemaking committee. The original hospice wage index was based on 1981 Bureau of Labor Statistics hospital data and had not been updated since 1983. In 1994, because of disparity in wages from one geographical location to another, the Hospice Wage Index Negotiated Rulemaking Committee was formed to negotiate a new wage index methodology that could be accepted by the industry and the government. This Committee was composed of representatives from national hospice associations; rural, urban, large and small hospices, and multi-site hospices; consumer groups; and a government representative. The Committee decided that in updating the hospice wage index, aggregate Medicare payments to hospices would remain budget neutral to payments calculated using the 1983 wage index, to cushion the impact of using a new wage index methodology. To implement this policy, a Budget Neutrality Adjustment Factor (BNAF) was computed and applied annually to the pre-floor, pre-reclassified hospital wage index when deriving the hospice wage index, subject to a wage index floor.

4. FY 2010 Hospice Wage Index Final Rule

Inpatient hospital pre-floor and pre-reclassified wage index values, as described in the August 8, 1997 Hospice Wage Index final rule, were subject to either a budget neutrality adjustment or application of the wage index floor. Wage index values of 0.8 or greater were

adjusted by the BNAF. Starting in FY 2010, a 7-year phase-out of the BNAF began (FY 2010 Hospice Wage Index final rule, (74 FR 39384, August 6, 2009)), with a 10 percent reduction in FY 2010, an additional 15 percent reduction for a total of 25 percent in FY 2011, an additional 15 percent reduction for a total 40 percent reduction in FY 2012, an additional 15 percent reduction for a total of 55 percent in FY 2013, and an additional 15 percent reduction for a total 70 percent reduction in FY 2014. The phase-out continued with an additional 15 percent reduction for a total reduction of 85 percent in FY 2015, and an additional, and final, 15 percent reduction for complete elimination in FY 2016. We note that the BNAF was an adjustment which increased the hospice wage index value. Therefore, the BNAF phase-out reduced the amount of the BNAF increase applied to the hospice wage index value. It was not a reduction in the hospice wage index value itself or in the hospice payment rates.

5. The Affordable Care Act

Starting with FY 2013 (and in subsequent FYs), the market basket percentage update under the hospice payment system referenced in sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(1)(C)(iii) of the Act is subject to annual reductions related to changes in economy-wide productivity, as specified in section 1814(i)(1)(C)(iv) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act).

In addition, sections 1814(i)(5)(A) through (C) of the Act, as added by section 3132(a) of the Affordable Care Act, require hospices to begin submitting quality data, based on measures to be specified by the Secretary of the Department of Health and Human Services (the Secretary), for FY 2014 and subsequent FYs. Beginning in FY 2014, hospices that fail to report quality data will have their market basket percentage increase reduced by 2 percentage points.

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the Affordable Care Act, requires, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary’s hospice care prior to the 180th-day

recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, we finalized in the CY 2011 Home Health Prospective Payment System final rule (75 FR 70435) that the 180th-day recertification and subsequent recertifications would correspond to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the Affordable Care Act, authorizes the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the Affordable Care Act could capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determined to be appropriate. The data collected could be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, we were required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

When the Medicare Hospice benefit was implemented, the Congress included an aggregate cap on hospice payments, which limits the total aggregate payments any individual hospice can receive in a year. The Congress stipulated that a "cap amount" be computed each year. The cap amount was set at \$6,500 per beneficiary when first enacted in 1983 and has been adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers from March 1984 to March of the cap year (section 1814(i)(2)(B) of the Act). The cap year was defined as the period from November 1st to October 31st. In the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314) for the 2012 cap year and subsequent cap years, we announced that subsequently, the hospice aggregate cap would be calculated using the patient-by-patient proportional methodology, within certain limits. We allowed existing hospices the option of having their cap calculated via the original streamlined methodology, also within certain limits. As of FY 2012, new hospices have their cap determinations calculated using the

patient-by-patient proportional methodology. The patient-by-patient proportional methodology and the streamlined methodology are two different methodologies for counting beneficiaries when calculating the hospice aggregate cap. A detailed explanation of these methods is found in the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314). If a hospice's total Medicare payments for the cap year exceed the hospice aggregate cap, then the hospice must repay the excess back to Medicare.

7. FY 2015 Hospice Wage Index and Payment Rate Update Final Rule

When electing hospice, a beneficiary waives Medicare coverage for any care for the terminal illness and related conditions except for services provided by the designated hospice and attending physician. The FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452) finalized a requirement that requires the Notice of Election (NOE) be filed within 5 calendar days after the effective date of hospice election. If the NOE is filed beyond this 5 day period, hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing (79 FR 50474). Similar to the NOE, the claims processing system must be notified of a beneficiary's discharge from hospice or hospice benefit revocation. This update to the beneficiary's status allows claims from non-hospice providers to be processed and paid. Late filing of the NOE can result in inaccurate benefit period data and leaves Medicare vulnerable to paying non-hospice claims related to the terminal illness and related conditions and beneficiaries possibly liable for any cost-sharing of associated costs. Upon live discharge or revocation, the beneficiary immediately resumes the Medicare coverage that had been waived when he or she elected hospice. The FY 2015 Hospice Wage Index and Payment Rate Update final rule also finalized a requirement that requires hospices to file a notice of termination/revocation within 5 calendar days of a beneficiary's live discharge or revocation, unless the hospices have already filed a final claim. This requirement helps to protect beneficiaries from delays in accessing needed care (§ 418.26(e)).

A hospice "attending physician" is described by the statutory and regulatory definitions as a medical doctor, osteopath, or nurse practitioner whom the beneficiary identifies, at the time of hospice election, as having the

most significant role in the determination and delivery of his or her medical care. Over time, we have received reports of problems with the identification of the person's designated attending physician and a third of hospice patients had multiple providers submit Part B claims as the "attending physician," using a claim modifier. The FY 2015 Hospice Wage Index and Payment Rate Update final rule finalized a requirement that the election form include the beneficiary's choice of attending physician and that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians (79 FR 50479).

Hospice providers are required to begin using a Hospice Experience of Care Survey for informal caregivers of hospice patients as of 2015. The FY 2015 Hospice Wage Index and Payment Rate Update final rule provided background and a description of the development of the Hospice Experience of Care Survey, including the model of survey implementation, the survey respondents, eligibility criteria for the sample, and the languages in which the survey is offered. The FY 2015 Hospice Rate Update final rule also set out participation requirements for CY 2015 and discussed vendor oversight activities and the reconsideration and appeals process for entities that failed to win CMS approval as vendors (79 FR 50496).

Finally, the FY 2015 Hospice Wage Index and Payment Rate Update final rule required providers to complete their aggregate cap determination not sooner than 3 months after the end of the cap year, and not later than 5 months after, and remit any overpayments. Those hospices that fail to timely submit their aggregate cap determinations will have their payments suspended until the determination is completed and received by the Medicare Administrative Contractor (MAC) (79 FR 50503).

8. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113-185) (IMPACT Act) became law on October 6, 2014. Section 3(a) of the IMPACT Act mandated that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025. In addition, section 3(c) of the IMPACT Act requires medical review of hospice cases involving beneficiaries receiving more than 180 days care in select hospices that show a preponderance of such patients; section 3(d) of the IMPACT Act contains a new provision

mandating that the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025 be updated by the hospice payment update rather than using the consumer price index for urban consumers (CPI-U) for medical care expenditures.

9. FY 2016 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2016 Hospice Rate Update final rule, we created two different payment rates for RHC that resulted in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for subsequent days of hospice care (80 FR 47172). We also created a Service Intensity Add-on (SIA) payment payable for services during the last 7 days of the beneficiary’s life, equal to the CHC hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse (RN) or social worker that occurs during the last 7 days (80 FR 47177).

In addition to the hospice payment reform changes discussed, the FY 2016 Hospice Wage Index and Payment Rate Update final rule implemented changes mandated by the IMPACT Act, in which the cap amount for accounting years that end after September 30, 2016 and before October 1, 2025 is updated by the hospice payment update percentage rather than using the CPI-U. This was applied to the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016. In addition, we finalized a provision to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the fiscal year for FY 2017 and later (80 FR 47186). This allows for the timely implementation of the IMPACT Act changes while better aligning the cap accounting year with the timeframe described in the IMPACT Act.

Finally, the FY 2016 Hospice Wage Index and Payment Rate Update final rule clarified that hospices must report all diagnoses of the beneficiary on the hospice claim as a part of the ongoing data collection efforts for possible future hospice payment refinements. Reporting of all diagnoses on the hospice claim aligns with current coding guidelines as

well as admission requirements for hospice certifications.

10. FY 2017 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2017 Hospice Wage Index and Payment Rate Update final rule, we finalized several new policies and requirements related to the HQRP. First, we codified our policy that if the National Quality Forum (NQF) makes non-substantive changes to specifications for HQRP measures as part of the NQF’s re-endorsement process, we will continue to utilize the measure in its new endorsed status, without going through new notice-and-comment rulemaking (81 FR 52160). We will continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures we have adopted for the HQRP; determinations about what constitutes a substantive versus non-substantive change will be made on a measure-by-measure basis. Second, we finalized two new quality measures for the HQRP for the FY 2019 payment determination and subsequent years: Hospice Visits when Death is Imminent Measure Pair and Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission (81 FR 52173). The data collection mechanism for both of these measures is the HIS, and the measures are effective April 1, 2017. Regarding the CAHPS® Hospice Survey, we finalized a policy that hospices that receive their CMS Certification Number (CCN) after January 1, 2017 for the FY 2019 Annual Payment Update (APU) and January 1, 2018 for the FY 2020 APU will be exempted from the Hospice CAHPS® requirements due to newness (81 FR 52182). The exemption is determined by CMS and is for 1 year only.

E. Trends in Medicare Hospice Utilization

Since the implementation of the hospice benefit in 1983, and especially within the last decade, there has been substantial growth in hospice benefit utilization. The number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to

nearly 1.4 million in FY 2016. Similarly, Medicare hospice expenditures have risen from \$2.8 billion in FY 2000 to approximately \$16.5 billion in FY 2016. Our Office of the Actuary (OACT) projects that hospice expenditures are expected to continue to increase, by approximately 7 percent annually, reflecting an increase in the number of Medicare beneficiaries, more beneficiary awareness of the Medicare Hospice Benefit for end-of-life care, and a growing preference for care provided in home and community-based settings.

There have also been changes in the diagnosis patterns among Medicare hospice enrollees. Specifically, as described in Table 2, there have been notable increases between 2002 and 2016 in neurologically-based diagnoses, including diagnoses of Alzheimer’s disease. Additionally, there have been significant increases in the use of non-specific, symptom-classified diagnoses, such as “debility” and “adult failure to thrive.” In FY 2013, “debility” and “adult failure to thrive” were the first and sixth most common hospice claims-reported diagnoses, respectively, accounting for approximately 14 percent of all diagnoses. Effective October 1, 2014, hospice claims are returned to the provider if “debility” and “adult failure to thrive” are coded as the principal hospice diagnosis as well as other ICD-9-CM (and as of October 1, 2015, ICD-10-CM) codes that are not permissible as principal diagnosis codes per ICD-9-CM (or ICD-10-CM) coding guidelines. In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452), we reminded the hospice industry that this policy would go into effect and claims would start to be returned to the provider effective October 1, 2014. As a result of this, there has been a shift in coding patterns on hospice claims. For FY 2016, the most common hospice principal diagnoses were Alzheimer’s disease, Heart Failure, Chronic Obstructive Pulmonary Disease, Lung Cancer, and Senile Degeneration of the Brain, which constituted approximately 30 percent of all claims-reported principal diagnosis codes reported in FY 2016 (see Table 2).

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2016

Rank	ICD-9/Reported Principal Diagnosis		Count	Percentage
Year: FY 2002				
1	162.9	Lung Cancer	73,769	11
2	428.0	Congestive Heart Failure	45,951	7
3	799.3	Debility Unspecified	36,999	6
4	496	COPD	35,197	5
5	331.0	Alzheimer’s Disease	28,787	4

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2016—Continued

6	436	CVA/Stroke	26,897	4
7	185	Prostate Cancer	20,262	3
8	783.7	Adult Failure To Thrive	18,304	3
9	174.9	Breast Cancer	17,812	3
10	290.0	Senile Dementia, Uncomp.	16,999	3
11	153.0	Colon Cancer	16,379	2
12	157.9	Pancreatic Cancer	15,427	2
13	294.8	Organic Brain Synd Nec	10,394	2
14	429.9	Heart Disease Unspecified	10,332	2
15	154.0	Rectosigmoid Colon Cancer	8,956	1
16	332.0	Parkinson's Disease	8,865	1
17	586	Renal Failure Unspecified	8,764	1
18	585	Chronic Renal Failure (End 2005)	8,599	1
19	183.0	Ovarian Cancer	7,432	1
20	188.9	Bladder Cancer	6,916	1

Year: FY 2007

1	799.3	Debility Unspecified	90,150	9
2	162.9	Lung Cancer	86,954	8
3	428.0	Congestive Heart Failure	77,836	7
4	496	COPD	60,815	6
5	783.7	Adult Failure To Thrive	58,303	6
6	331.0	Alzheimer's Disease	58,200	6
7	290.0	Senile Dementia Uncomp.	37,667	4
8	436	CVA/Stroke	31,800	3
9	429.9	Heart Disease Unspecified	22,170	2
10	185	Prostate Cancer	22,086	2
11	174.9	Breast Cancer	20,378	2
12	157.9	Pancreas Unspecified	19,082	2
13	153.9	Colon Cancer	19,080	2
14	294.8	Organic Brain Syndrome NEC	17,697	2
15	332.0	Parkinson's Disease	16,524	2
16	294.10	Dementia in Other Diseases w/o Behavior Dist.	15,777	2
17	586	Renal Failure Unspecified	12,188	1
18	585.6	End Stage Renal Disease	11,196	1
19	188.9	Bladder Cancer	8,806	1
20	183.0	Ovarian Cancer	8,434	1

Year: FY 2013

1	799.3	Debility Unspecified	127,415	9
2	428.0	Congestive Heart Failure	96,171	7
3	162.9	Lung Cancer	91,598	6
4	496	COPD	82,184	6
5	331.0	Alzheimer's Disease	79,626	6
6	783.7	Adult Failure to Thrive	71,122	5
7	290.0	Senile Dementia, Uncomp.	60,579	4
8	429.9	Heart Disease Unspecified	36,914	3
9	436	CVA/Stroke	34,459	2
10	294.10	Dementia in Other Diseases w/o Behavioral Dist.	30,963	2
11	332.0	Parkinson's Disease	25,396	2
12	153.9	Colon Cancer	23,228	2
13	294.20	Dementia Unspecified w/o Behavioral Dist.	23,224	2
14	174.9	Breast Cancer	23,059	2
15	157.9	Pancreatic Cancer	22,341	2
16	185	Prostate Cancer	21,769	2
17	585.6	End-Stage Renal Disease	19,309	1
18	518.81	Acute Respiratory Failure	15,965	1
19	294.8	Other Persistent Mental Dis.—classified elsewhere	14,372	1
20	294.11	Dementia In Other Diseases w/Behavioral Dist.	13,687	1

Year: FY 2016

1	G30.9	Alzheimer's disease, unspecified	162,845	11
2	I50.9	Heart failure, unspecified	84,088	6
3	J44.9	Chronic obstructive pulmonary disease, unspecified	74,131	5
4	C34.90	Malignant Neoplasm of Unsp Part of Unsp Bronchus or Lung	57,077	4
5	G31.1	Senile degeneration of brain, not elsewhere classified	55,305	4
6	G20	Parkinson's disease	37,245	2
7	I25.10	Atherosclerotic heart disease of native coronary art without angina pectoris	33,647	2
8	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	32,851	2
9	G30.1	Alzheimer's disease with late onset	29,223	2
10	I67.2	Cerebral atherosclerosis	27,629	2
11	C61	Malignant neoplasm of prostate	24,576	2

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2016—Continued

12	N18.6	End stage renal disease	22,261	1
13	C18.9	Malignant neoplasm of colon, unspecified	22,203	1
14	I51.9	Heart disease, unspecified	21,868	1
15	C25.9	Malignant neoplasm of pancreas, unspecified	20,400	1
16	I63.9	Cerebral infarction, unspecified	18,546	1
17	I67.9	Cerebrovascular disease, unspecified	14,879	1
18	C50.919	Malignant neoplasm of unspecified site of unspecified female breast	14,022	1
19	A41.9	Sepsis, unspecified organism	12,723	1
20	I50.22	Chronic systolic (congestive) heart failure	12,083	1

Note(s): The frequencies shown represent beneficiaries that had at least one claim with the specific ICD–9–CM/ICD–10 code reported as the principal diagnosis. Beneficiaries could be represented multiple times in the results if they have multiple claims during that time period with different principal diagnoses.

Source: FY 2002 and 2007 hospice claims data from the Chronic Conditions Data Warehouse (CCW), accessed on February 14 and February 20, 2013. FY 2013 hospice claims data from the CCW, accessed on June 26, 2014, and FY 2016 hospice claims data from the CCW, accessed and merged with ICD–10 codes on January 9, 2017.

While there has been a shift in the reporting of the principal diagnosis as a result of diagnosis clarifications, a significant proportion of hospice claims (49 percent) in FY 2014 only reported a single principal diagnosis, which may not fully explain the characteristics of Medicare beneficiaries who are approaching the end of life. To address this pattern of single diagnosis reporting, the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50498) reiterated ICD–9–CM coding guidelines for the reporting of the principal and additional diagnoses on the hospice claim. We reminded providers to report all diagnoses on the hospice claim for the terminal illness and related conditions, including those that affect the care and clinical management for the beneficiary. Additionally, in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47201), we provided further clarification regarding diagnosis reporting on hospice claims. We clarified that hospices will report *all* diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, effective October 1, 2015. Analysis of FY 2016 hospice claims shows that 100 percent of hospices reported more than one diagnosis, with 86 percent submitting at least two diagnoses and 77 percent including at least three diagnoses.

III. Provisions of the Proposed Rule

A. Monitoring for Potential Impacts—Affordable Care Act Hospice Reform

1. Hospice Payment Reform: Research and Analyses

This section of the proposed rule describes current trends in hospice utilization and provider behavior, such as lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending. Utilization

data on these metrics were examined to determine the potential impacts related to the hospice reform policies finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142), if any. Moreover, in response to Office of Inspector General (OIG) report “Hospice Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care” (OEI–02–10–00491) released in March 2016, which identified the drugs paid for by Part D and provided to beneficiaries during general inpatient care (GIP) stays, we have also continued to monitor non-hospice spending during a hospice election as described in this section. Additionally, we have included preliminary information on the costs of hospice care using data from the new hospice Medicare cost report, effective for cost reporting periods that began on or after October 1, 2014 (FY 2015). Section 1814(i)(6) of the Act, as amended by section 3132(a)(1)(B) of the Affordable Care Act, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes, including such data sources as the Medicare cost reports. These preliminary analyses may inform future work that could include such refinements to hospice payment rates.

a. Length of Stay and Live Discharges Hospice Length of Stay

Eligibility under the Medicare hospice benefit is predicated on the individual being certified as terminally ill. Medicare regulations at § 418.3 define “terminally ill” to mean that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. However, we have recognized in previous rules that prognostication is not an exact science (79 FR 50470), and thus, a beneficiary may be under a hospice election longer than 6 months, as long as there remains a reasonable

expectation that the individual has a life expectancy of 6 months or less.

The number of days that a hospice beneficiary receives care under a hospice election is referred to as the hospice length of stay. Hospice length of stay can be influenced by a number of factors including disease course, timing of referral, decision to resume curative treatment, and/or stabilization or improvement where the individual is no longer certified as terminally ill. Longer lengths of stay in hospice may reflect admission to hospice earlier in the disease trajectory or miscalculation of prognosis, among other situations. Shorter lengths of stay in hospice may reflect hospice election late in the disease trajectory or a rapidly progressing acute condition. This also may be due to individual reluctance to accept that his or her condition is terminal and choose the hospice benefit; inadequate knowledge regarding the breadth of services available under hospice care; cultural, ethnic, and/or religious backgrounds inhibiting or even precluding the use of hospice services; and other reasons.⁴ As such, hospice lengths of stay are variable.

We examined length of stay, meaning the number of hospice days during a single hospice election at the date of live discharge or death. We also examined total *lifetime* length of stay, which would include the sum of all days of hospice care across all hospice elections. This would mean if a beneficiary had one hospice election, was discharged alive, and then re-elected the benefit at a later date, the sum of both elections would count towards their lifetime length of stay. In FY 2016, the average length of stay in hospice was 79 days and the average *lifetime* length of stay in hospice was

⁴ Vig, E., Starks, H., Taylor, J., Hopley, E., Fryer-Edwards, K. (2010). “Why Don’t Patients Enroll in Hospice? Can We Do Anything About It?” *Journal of General Internal Medicine*. 25(10): 1009–19. Doi: 10.1007/s11606-010-1423-9.

96.1 days. The average length of stay remained virtually the same between FY 2015 and FY 2016, 78 days compared to 79 days, respectively. The average lifetime length of stay similarly remained virtually the same between FY 2015 and FY 2016, 95.2 and 96.1 days, respectively.

The median (50th percentile) length of stay in FY 2016 was 18 days. This means that half of hospice beneficiaries received care for fewer than 18 days and half received care for more than 18 days.

While the median length of stay has remained relatively constant over the past several years, the average length of stay has typically increased from year to year.

The Medicare hospice benefit provides four levels of care: Routine home care (RHC), general inpatient care (GIP), continuous home care (CHC), and inpatient respite care (IRC). The majority of hospice patient care is provided at the RHC level of care and can be provided wherever the patient

calls “home,” including nursing homes and assisted living facilities. As indicated in Table 3 below, most hospice care (98 percent) provided is routine home care (RHC). Approximately 56 percent of all hospice days are provided at the RHC level of care in the patient’s residence whereas 41 percent is provided at the RHC level of care to patients that reside in a nursing home or assisted living facility.

TABLE 3—SHARE OF HOSPICE DAYS BY LEVEL OF CARE AND SITE OF SERVICE, FOR BENEFICIARIES DISCHARGED ALIVE OR DECEASED IN FY 2016

Level of care	Site of service	Number of hospice days	% of all hospice days
RHC	Home + Hospice Residential Facility	59,818,337	55.75
	SNF/NF	25,953,198	24.19
	Assisted Living Facility	18,182,931	16.95
	Other	1,224,979	1.14
	Total	105,179,445	98.02
GIP	Inpatient Hospital	378,792	0.35
	Inpatient Hospice Facility	1,060,487	0.99
	Skilled Nursing Facility	59,158	0.06
	Other	5,571	0.01
	Total	1,504,008	1.40
CHC	Home + Hospice Residential Facility	180,206	0.17
	SNF/NF	42,224	0.04
	Assisted Living Facility	69,849	0.07
	Other	484	0.00
	Total	292,763	0.27
IRC	Inpatient Hospital	29,895	0.03
	Inpatient Hospice Facility	111,004	0.10
	SNF/NF	185,351	0.17
	Other	1,490	0.00
	Total	327,740	0.31
Total		107,303,956	100

Source: Common Working File (CWF). All hospice claims from 2006 to 2016 were included, for beneficiaries whose final claim in FY 2016, according to through date, for a hospice discharge (excluded status code “30”, indicating a continuing patient). Hospice days with invalid or missing site of service HCPCS code are excluded.

In addition to analyzing the hospice average and average lifetime lengths of stay, we examined the average lifetime lengths of stay associated with hospice principal diagnoses by site of service at admission in FY 2015 (see Table 4 below). We limited our analysis to those beneficiaries that were receiving RHC at

admission. As noted in Table 3 above, RHC was the level of care for 98 percent of all hospice days. We found that beneficiaries with chronic, progressive neurological diseases such as Alzheimer’s disease and related dementias, and Parkinson’s disease had the longest average lifetime lengths of

stay at 165.3 days in FY 2015. Beneficiaries with Chronic Kidney Disease and cancer had shorter average lifetime lengths of stay, 57 and 63.7 days, respectively. For all diagnoses, the average lifetime length of stay was 113.5 days in FY 2015 when level of care at admission is RHC.

TABLE 4—AVERAGE LIFETIME LENGTH OF STAY BY DIAGNOSIS AND SITE OF SERVICE ON THE DAY OF ADMISSION IN FY 2015, WHEN LEVEL OF CARE AT ADMISSION IS RHC

Primary hospice diagnosis at admission	Home + hospice residential facility		Assisted living facility		SNF + LTC or non-skilled nursing facility		Other		All sites of service	
	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay
All Diagnoses	576,657	106.75	101,085	159.77	208,747	106.21	9,530	90.90	897,298	113.51

TABLE 4—AVERAGE LIFETIME LENGTH OF STAY BY DIAGNOSIS AND SITE OF SERVICE ON THE DAY OF ADMISSION IN FY 2015, WHEN LEVEL OF CARE AT ADMISSION IS RHC—Continued

Primary hospice diagnosis at admission	Home + hospice residential facility		Assisted living facility		SNF + LTC or non-skilled nursing facility		Other		All sites of service	
	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay
Alzheimer's, Dementia, and Parkinson's ..	83,527	172.45	39,019	186.89	67,438	140.34	2,314	143.33	192,593	165.32
CVA/Stroke	32,329	95.82	9,359	98.97	23,927	77.17	971	53.56	66,668	90.06
Cancers	233,771	62.04	11,773	93.90	30,437	63.23	1,964	46.41	278,047	63.69
Chronic Kidney Disease	14,328	58.41	1,655	82.34	6,644	47.60	273	48.84	22,907	57.01
Heart (CHF and Other Heart Disease)	101,243	121.77	19,784	131.11	35,052	83.54	1,771	84.69	158,167	115.14
Lung (COPD and Pneumonias)	58,183	131.97	6,866	127.83	16,631	82.42	870	65.42	82,656	122.11
All Other Diagnoses	53,276	163.47	12,629	254.83	28,618	150.98	1,367	125.28	96,260	173.36

Source: Common Working File (CWF). All hospice claims from 2006 to 2015 were included, for beneficiaries whose final claim in FY 2015, according to through date, for a hospice discharge (excluded status code "30", indicating a continuing patient). Diagnosis code and site of service were determined by the first hospice claim for a beneficiary. Diagnosis categories are consistent with those outlined in Abt's 2015 technical report (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/December-2015-Technical-Report.pdf>).

Note 1: "Other" category includes inpatient hospital, inpatient hospice facility, LTCH, IPF, and places not otherwise specified. Although dementia was no longer a valid primary diagnosis for the hospice benefit, our study time period examines primary diagnoses dating back to 2006.

Note 2: The data used for this table spans multiple years (2006 and forward). We were not able to convert ICD-9-CM diagnosis codes to ICD-10-CM codes, given the inherent complexities with appropriately mapping ICD-9-CM codes to ICD-10-CM codes, in time for this proposed rule. Therefore, we limited this analysis to those hospice patients that were discharged (alive or deceased) in FY 2015.

As we indicated above, the average lifetime length of stay across all levels of care at admission was 96.1 days in FY 2016. However, the average lifetime length of stay was 114 days in FY 2016 when the level of care was RHC at admission (see Table 5 below). This

suggests that beneficiaries not receiving RHC level of care at admission had shorter lifetime lengths of stay compared to the beneficiaries whose level of care was RHC at admission. In particular, those beneficiaries who are admitted to hospice at the GIP level of

care typically are more acute and often die without transitioning to RHC and thus, have overall shorter lengths of stay. Therefore, the shorter lengths of stay for those admitted at the GIP level of care affect the overall average lifetime length of stay across all levels of care.

TABLE 5—AVERAGE LIFETIME LENGTH OF STAY LEVEL OF CARE TO RHC AT ADMISSION, FY 2015–FY 2016

	FY 2015		FY 2016	
	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay
Any Level of Care at Admission	1,111,967	95.16	1,117,643	96.14
RHC at Admission	897,298	113.51	909,961	114.02

Source: Common Working File (CWF). All hospice claims from 2006 to 2016 were included, for beneficiaries whose final claim in FY 2016, according to through date, for a hospice discharge (excluded status code "30", indicating a continuing patient).

Live Discharges

A beneficiary who has elected hospice may revoke his or her hospice election at any time and for any reason. The regulations state that if the hospice beneficiary (or his or her representative) revokes the hospice election, the beneficiary may, at any time, re-elect to receive hospice coverage for any other hospice election period that he or she is eligible to receive (§ 418.24(e) and § 418.28(c)(3)). Immediately upon hospice revocation, Medicare coverage resumes for those Medicare benefits previously waived with the hospice election. A revocation can only be made by the beneficiary, in writing, and must specify the effective date of the revocation. A hospice cannot "revoke" a beneficiary's hospice election, nor is it appropriate for hospices to encourage, request, or demand that the beneficiary or his or her representative revoke his or her hospice election. Like the hospice

election, a hospice revocation is to be an informed choice based on the beneficiary's goals, values and preferences for the services the person wishes to receive through Medicare.

Federal regulations limit the circumstances in which a Medicare hospice provider may discharge a patient from its care. In accordance with § 418.26, discharge from hospice care is permissible when the patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause. Hospices may not discharge the patient at their discretion, even if the care may be costly or inconvenient for the hospice program. As we indicated in the FY 2015 Hospice Wage Index and Payment Rate Update proposed and final rules, we understand that the rate of live discharges should not be zero, given the uncertainties of prognostication and the ability of beneficiaries and their families to

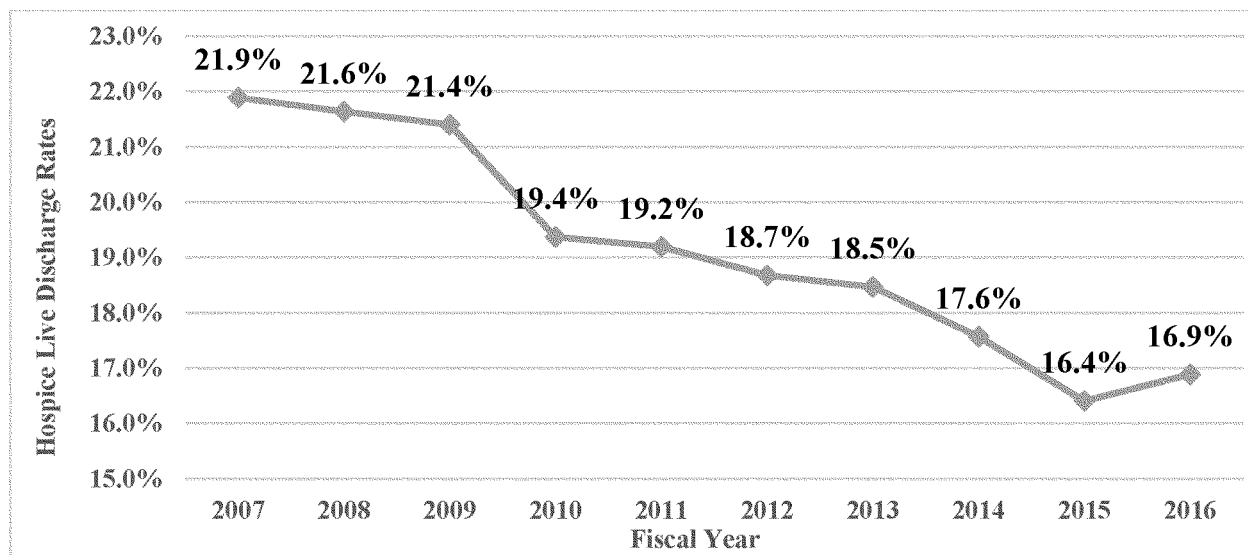
revoke the hospice election at any time (79 FR 26549 and 79 FR 50463). On July 1, 2012, we began collecting discharge information on the claim to capture the reason for all types of discharges which includes, death, revocation, transfer to another hospice, moving out of the hospice's service area, discharge for cause, or due to the beneficiary no longer being considered terminally ill (that is, no longer qualifying for hospice services). In FY 2016, approximately 17 percent of hospice beneficiaries were discharged alive (see Figure 1 below). Beneficiary revocations represented 38 percent of all live discharges whereas 51 percent of live discharges were instances where the beneficiary was discharged because the beneficiary was considered no longer terminally ill, and 11 percent of live discharges were instances where beneficiaries transferred to other hospices. In analyzing hospice live discharge rates

over time, Figure 1 demonstrates an incremental decrease in average annual rates of live discharge rates from FY

2007 to FY 2015, but an increase in the live discharge rate between FY 2015 and FY 2016. Between FY 2007 and FY

2016, there has been a reduction in the live discharge rate of 22.8 percent over this time period.

Figure 1: Annual Live Discharge Rates for FY 2007 to FY 2016



Source: FY 2007 through FY 2016 hospice claims data from Common Working File (CWF). All hospice claims were examined that list a discharge status code (meaning claims were excluded if they listed status code 30, indicating a continuing patient). Live discharges were defined as hospice claims with a status code of "01".

As part of our ongoing monitoring efforts, we analyzed the distribution of live discharge rates among hospices with 50 or more discharges (discharged alive or deceased). Table 6 shows that

there is significant variation in the rate of live discharge between the 10th and 90th percentiles. Most notably, hospices at the 95th percentile discharged 49.1 percent of their patients alive in FY

2016. While the live discharge rate in FY 2016 for every percentile has decreased compared to FY 2014, the median live discharge rate remains around 17 percent.

TABLE 6—DISTRIBUTION OF LIVE DISCHARGE RATES FOR HOSPICES WITH 50 OR MORE LIVE DISCHARGES, FY 2014 TO FY 2016

Statistics	Live discharge rate		
	FY 2014	FY 2015	FY 2016
5th Percentile	7.5%	6.9%	6.8%
10th Percentile	9.0%	8.5%	8.4%
25th Percentile	12.4%	11.6%	11.6%
Median	17.6%	16.8%	16.9%
75th Percentile	26.5%	24.6%	25.4%
90th Percentile	39.4%	35.9%	37.2%
95th Percentile	50.0%	45.6%	49.1%
# Providers	3,160	3,215	3,232

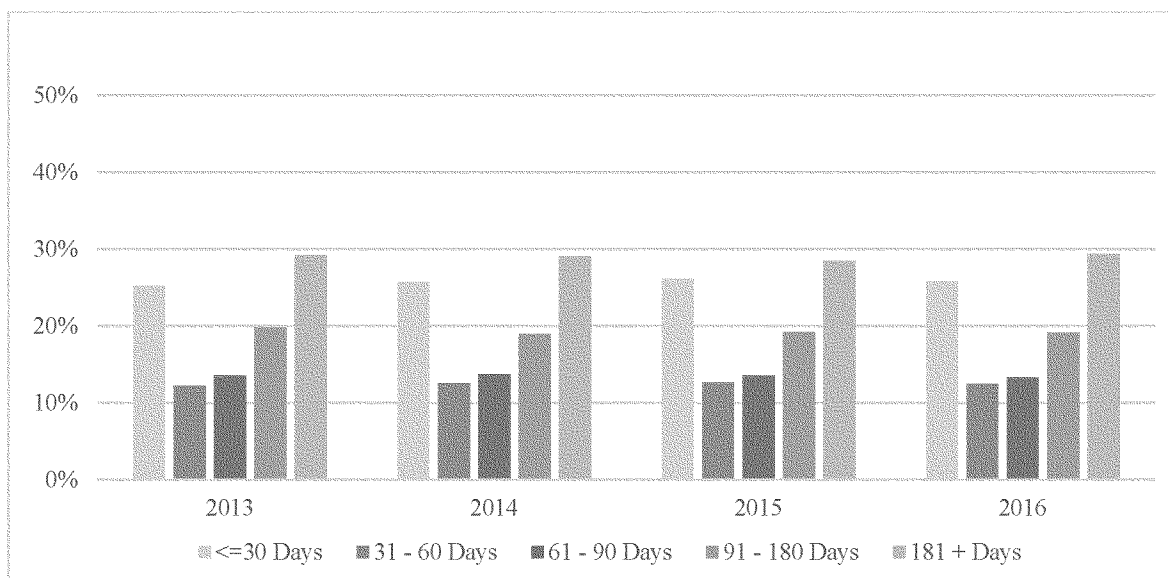
Source: FY 2014, FY 2015, and FY 2016 hospice claims data from Common Working File (CWF) that list a discharge status code (meaning claims were excluded if they listed status code 30, indicating a continuing patient). Live discharges were defined as hospice claims with a status code of "01".

Finally, we looked at the distribution of live discharges by length of stay intervals. In looking at the length of stay intervals, 26 percent of the live discharges occurred within 30 days of the start of hospice care, 13 percent between 31 to 60 days, 14 percent between 61 to 90 days, 19 percent

between 91 to 180 days, and 28 percent of live discharges occurred after a length of stay over 180 days of hospice care (see Figure 2 below). The proportion of live discharges occurring between the length of stay intervals was relatively constant from FY 2013 to FY 2016. Overall, our analyses do not reveal any

anomalies in trends in lengths of stay and rates of live discharge at this time. However, we will continue to monitor the data available so as to identify any concerning behavior in response to recent payment policy reforms.

Figure 2. Length of Stay Intervals Distribution for Live Discharges, FY 2013 to FY 2016



Source: FY 2013 – FY 2016 final hospice claims from Common Working File (CWF).

b. Skilled Visits in the Last Days of Life

As we noted in both the FY 2016 and FY 2017 Hospice Wage Index and Payment Rate Update final rules (80 FR 47164 and 81 FR 52143, respectively), we are concerned that many hospice beneficiaries may not be receiving skilled visits during the last days of life. In the period of time immediately preceding death, patient needs typically surge and more intensive services are warranted, so we expect that the provision of care would proportionately escalate in order to meet the increased clinical, emotional, and other needs of the hospice beneficiary and his or her family and caregiver(s). The last week of life is typically the period within the terminal illness trajectory that is associated with the highest symptom burden, typically marked by impactful physical and emotional symptoms, necessitating attentive care and engagement from the integrated hospice team.

In the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47164 through 47177), the Service Intensity Add-on (SIA) payment policy was finalized with an implementation date of January 1, 2016. This payment was developed in part with the objective

of encouraging visits during the last days of life. Additionally, in the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52143) we finalized two new hospice quality reporting program (HQRP) measures, effective April 1, 2017: (1) Hospice Visits When Death is Imminent, assessing hospice staff visits to patients and caregivers in the last week of life; and (2) Hospice and Palliative Care Composite Process Measure, assessing the percentage of hospice patients who received care processes consistent with existing guidelines. These efforts represent meaningful advances in encouraging visits to hospice beneficiaries during the time period preceding death.

In the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47164), commenters expressed concern regarding potential impacts of the new payment policies. Some noted that the new payment structures could potentially impact patient access to hospice care and articulated concerns around provider jettisoning of hospice beneficiaries, specifically around the 60-day mark of a hospice stay. In response to these concerns, we pledged to monitor real-time hospice data, evaluating for any shifts in utilization or

provision of services to Medicare beneficiaries.

As part of our monitoring efforts, we assessed the delivery of hospice care during the period of time preceding death. Analysis of FY 2016 claims data, which encompasses hospice claims from October 1, 2015 through September 30, 2016, shows that on any given day during the last 7 days of a hospice election, nearly 44 percent of the time the patient has not received a skilled visit (skilled nursing or social worker visit) (see Table 7 below). This figure represents an incremental improvement when compared to the figures presented in our FY 2017 Hospice Wage Index and Payment Rate Update proposed rule (81 FR 25515), where FY 2014 claims showed approximately 46 percent for this metric. Additionally, Table 7 shows that approximately 21 percent of beneficiaries did not receive a skilled visit (skilled nursing or social work visit) on the day of death in FY 2016. This value also indicates an improvement compared to the FY 2014 claims data, in which nearly 26 percent of hospice beneficiaries did not receive a skilled visit on the day of death (81 FR 25515).

TABLE 7—FREQUENCY AND LENGTH OF SKILLED NURSING AND SOCIAL WORK VISITS (COMBINED) DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2016

Visit length	Days Before Death							All 7 days combined (%)
	0 days (day of death) (%)	1 day (%)	2 days (%)	3 days (%)	4 days (%)	5 days (%)	6 days (%)	
No Visit	21.2	36.7	43.7	48.9	53.1	55.8	58.0	43.6
15 Minutes to 1 Hour	25.6	30.0	28.2	26.7	25.2	24.4	23.7	26.5
1 Hour, 15 Minutes to 2 Hours	26.8	20.0	17.8	15.9	14.5	13.5	12.6	17.9
2 Hours, 15 Minutes to 3 Hours	13.8	7.1	5.8	4.9	4.3	3.9	3.5	6.6
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	4.8	2.3	1.8	1.5	1.2	1.1	1.0	2.1
4 or More Hours	7.8	3.9	2.7	2.1	1.7	1.4	1.2	3.3

Source: FY 2016 hospice claims data from Common Working File (CWF) (as of December 9, 2016).

While Table 7 above shows the frequency and length of skilled nursing and social work visits combined during the last 7 days of a hospice election in FY 2016, Tables 8 and 9 below show the frequency and length of visits for skilled nursing and social work separately.

Analysis of FY 2016 claims data shows that on any given day during the last 7 days of a hospice election, almost 47 percent of the time the patient had not received a visit by a skilled nurse, and 90 percent of the time the patient had not received a visit by a social worker

(see Tables 8 and 9, respectively). We believe it is important to ensure that beneficiaries and their families and caregivers are, in fact, receiving the level of care necessary during critical periods such as the very end of life.

TABLE 8—FREQUENCY AND LENGTH OF SKILLED NURSING VISITS DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2016

Visit length	Days Before Death							All 7 days combined (%)
	0 days (day of death) (%)	1 day (%)	2 days (%)	3 days (%)	4 days (%)	5 days (%)	6 days (%)	
No Visit	22.7	39.6	46.9	52.2	56.5	59.2	61.5	46.5
15 Minutes to 1 Hour	26.4	31.5	29.1	27.0	25.2	24.1	23.2	27.0
1 Hour, 15 Minutes to 2 Hours	27.3	19.0	16.8	14.9	13.4	12.5	11.5	17.2
2 Hours, 15 Minutes to 3 Hours	13.2	5.4	4.2	3.5	3.0	2.7	2.4	5.4
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	4.1	1.6	1.2	0.9	0.7	0.7	0.6	1.5
4 or More Hours	6.2	2.9	1.9	1.4	1.2	1.0	0.8	2.4

Source: FY 2016 hospice claims data from Common Working File (CWF) (as of December 9, 2016).

TABLE 9—FREQUENCY AND LENGTH OF SOCIAL WORK VISITS DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2016

Visit length	Days Before Death							All 7 days combined
	0 days (day of death) (%)	1 day (%)	2 days (%)	3 days (%)	4 days (%)	5 days (%)	6 days (%)	
No Visit	89.9	87.1	88.6	89.7	90.5	91.1	91.4	89.6
15 Minutes to 1 Hour	6.3	8.8	7.8	7.1	6.6	6.3	6.1	7.1
1 Hour, 15 Minutes to 2 Hours	2.7	3.4	3.0	2.7	2.5	2.3	2.2	2.7
2 Hours, 15 Minutes to 3 Hours	0.7	0.5	0.4	0.4	0.3	0.3	0.3	0.4
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	0.2	0.1	0.1	0.0	0.0	0.0	0.0	0.1
4 or More Hours	0.2	0.1	0.1	0.0	0.0	0.0	0.0	0.1

Source: FY 2016 hospice claims data from Common Working File (CWF) (as of December 9, 2016).

Additionally, we have analyzed the overall levels of nursing and medical social services provided during the 7

days prior to death. In an assessment of FY 2015 claims, we estimate that the total number of hours of skilled

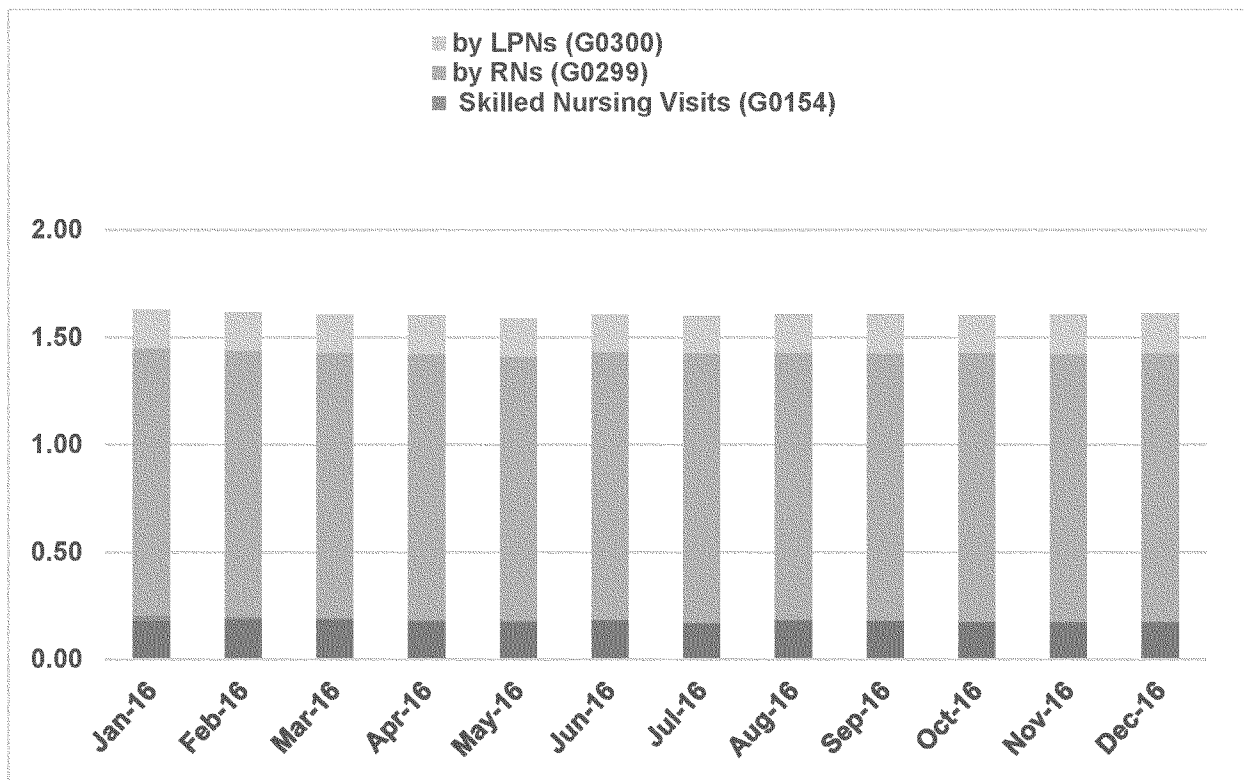
services, including skilled nursing (as reported with code G0154) and medical social services visits, provided to

Medicare hospice beneficiaries in the RHC level of care in the 7 days preceding death was approximately 1.61 hours per day. As depicted in Figure 3 below, from our analysis of FY 2016 hospice claims data that begins January 1, 2016 and spans through December 31, 2016, a relatively consistent level of nursing and medical social services visits are being provided among RHC days in the 7 days prior to death,

averaging around 1.6 hours per day. For the period spanning January 1, 2016 through December 31, 2016, our analysis shows that approximately 1.24 hours of services were provided by RNs, 0.18 hours were provided by LPNs, and 0.18 hours were provided by social workers per day. We note that for purposes of the SIA payment, only those hours of service provided by an RN, which became separately categorized as

G0299 beginning January 1, 2016, and medical social worker count toward the calculation of the SIA payment. Additionally, we note that G0154 was retired as of January 1, 2016; however, this code was still reported by some providers in the months of January and February 2016, and thus was included in Figure 3.

Figure 3: Visit Hours per Day in the Last Seven Days of Life, CY 2016



Source: Medicare hospice claims, January 1, 2016 through December 31, 2016; RHC days only; claims extracted on February 17, 2017 from Common Working File (CWF).

Given this evaluation of the initial wave of data, which now encompasses the payment policy changes that began on January 1, 2016, we do not believe that the results highlight any immediate concerns regarding behavior changes among hospices, and it appears that beneficiaries are receiving similar levels of care when compared to time periods prior to the implementation of the payment policy reforms. As more complete data become available, we will continue to monitor the provision of services at end-of-life and impacts of the SIA payment and other policies.

c. Non-Hospice Spending

When a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment

for services related to the treatment of the individual’s condition with respect to which a diagnosis of terminal illness has been made, except for services provided by the designated hospice and the attending physician. Hospice services are comprehensive and we have reiterated since 1983 that “virtually all” care needed by the terminally ill individual would be provided by hospice. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life. However, we continue to conduct ongoing analysis of non-hospice spending during a hospice election and the results of our analysis seems to suggest the unbundling of items and services that perhaps should

have been provided and covered under the Medicare hospice benefit.

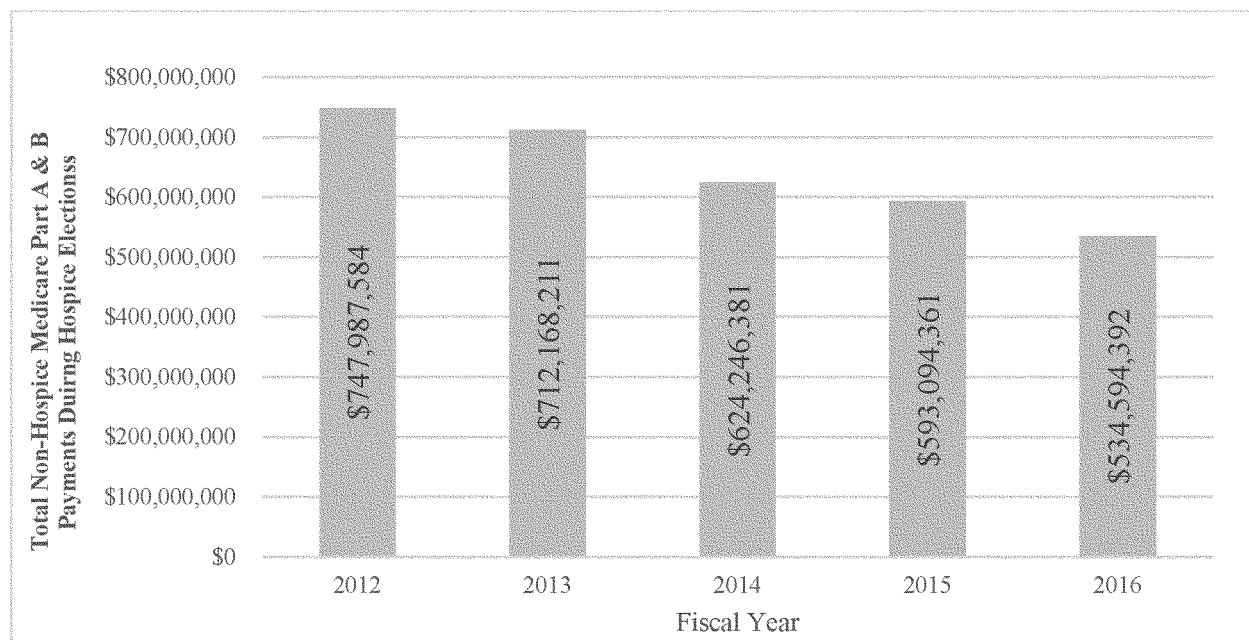
We first reported findings on 2012 non-hospice spending during a hospice election in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452). This proposed rule updates our analysis of non-hospice spending during a hospice election using FY 2016 data. We found that in FY 2016, Medicare paid over \$900 million for items and services under Parts A, B, and D for beneficiaries during a hospice election. Medicare payments for non-hospice Part A and Part B items and services received by hospice beneficiaries during hospice election were \$748 million in FY 2012, \$712 million in FY 2013, \$624 million in FY 2014, \$593 million in FY 2015,

and \$534 million in FY 2016 (see Figure 4 below). The beneficiary cost sharing amount in FY 2016 was \$129.6 million. Non-hospice spending for Part A and Part B items and services has decreased

each year since we began reporting these findings. Overall, from FY 2012 to FY 2016 non-hospice Medicare spending for Parts A and B during hospice election declined 25 percent.

However, there continues to be a non-trivial amount of non-hospice Parts A and B spending on beneficiaries under a hospice election, and we will continue to monitor data regarding this issue

Figure 4: Medicare Payments for Non-Hospice Medicare Part A and Part B items and services during Hospice Elections, FY 2012 – FY 2016



Source: Analysis of 100 percent Medicare Part A and Part B claims data from Common Working File (CWF) (final action claims), FY 2010 through FY 2016, excluding utilization on hospice admission or live discharge days.

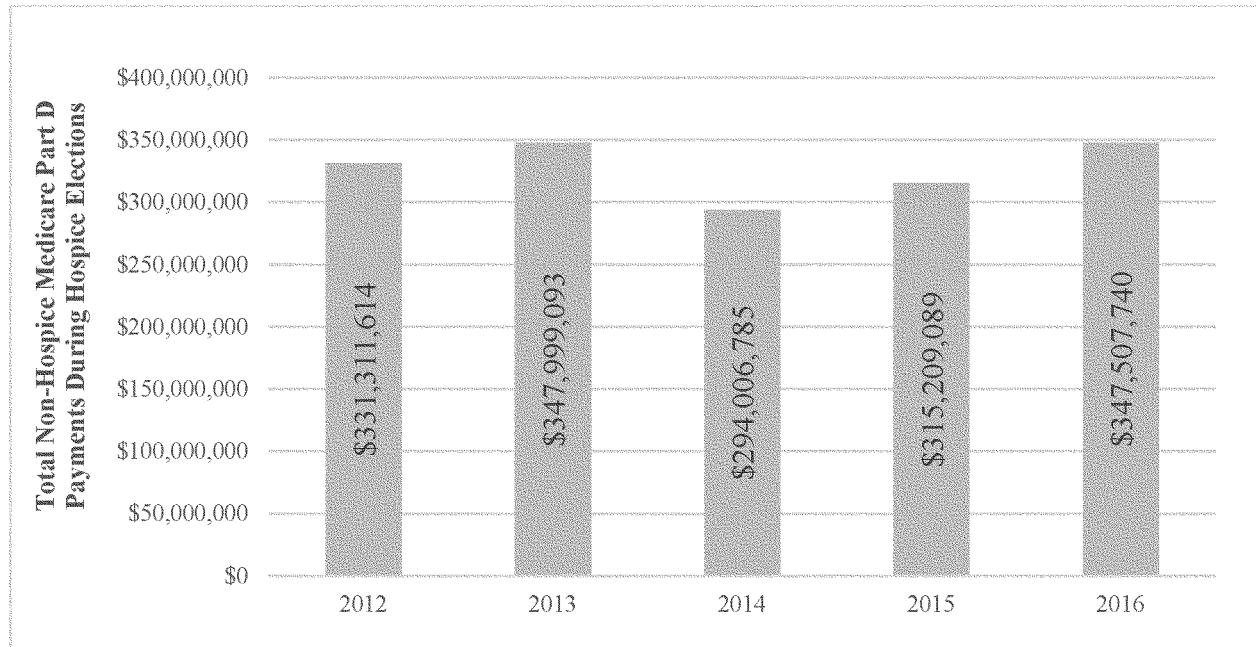
We also examined Part D spending from FY 2012 to FY 2016 for those beneficiaries under a hospice election. The data shows Medicare payments for non-hospice Part D drugs received by hospice beneficiaries during a hospice election were \$331.3 million in FY 2012, \$348 million in FY 2013, \$294 million in FY 2014, \$315.2 million in FY 2015, and \$347.5 million in FY 2016 (see Figure 5). In contrast to non-hospice spending during a hospice election for Medicare Parts A and B items and services, non-hospice spending for Part D drugs increased in FY 2016 compared to FY 2012.

Recent analyses of Part D prescription drug event (PDE) data suggest that the current prior authorization (PA) has reduced Part D program payments for drugs in four targeted categories (analgesics, anti-nauseants, anti-anxiety, and laxatives). However, under Medicare Part D there has been an increase in hospice beneficiaries filling prescriptions for a separate category of drugs we refer to as maintenance drugs, as recently analyzed by CMS.⁵ Currently, maintenance drugs for beneficiaries under a hospice election are not subject to the Part D PA process. After a hospice election, many maintenance drugs as well as drugs

used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, there are maintenance drugs that are appropriate to continue as they may offer symptom relief for the palliation and management of the terminal illness and related conditions, and therefore should be covered under the hospice benefit, not Part D. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes. These categories include beta blockers, calcium channel blockers, corticosteroids, and insulin.

⁵ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf>.

Figure 5: Medicare Payments for Non-Hospice Medicare Part D Prescription Drugs during Hospice Elections, FY 2012 - FY 2016



Source: Analysis of 100% FY 2012 through FY 2015 Part D TAP data listing a drug for a valid Generic Product Identifier (GPI).

Table 10 below details the various components of Part D spending for patients receiving hospice care for FY 2016. The portion of the \$436.1 million total Part D spending that was paid by Medicare is the sum of the Low Income Cost-Sharing Subsidy (row 2 in Table 10) and the Covered Drug Plan Paid Amount (row 5), or approximately \$347.5 million. The beneficiary cost sharing amount was approximately \$64.9 million, including patient pay amount (row 1), other true out-of-pocket amount (row 3), and patient liability reduction due to other payer amount (row 4).

TABLE 10—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES’ FY 2016 DRUGS RECEIVED THROUGH PART D—Continued

Component	FY 2016 expenditures
Gross Total Drug Costs, Reported	436,130,318

Source: Analysis of 100% FY 2016 Medicare Claim Files. For more information on the components above and on Part D data, go to the Research Data Assistance Center’s (ResDAC’s) Web site at: <http://www.resdac.org/>.

TABLE 10—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES’ FY 2016 DRUGS RECEIVED THROUGH PART D

Component	FY 2016 expenditures
Patient Pay Amount	\$47,289,374
Low Income Cost-Sharing Subsidy	103,715,821
Other True Out-of-Pocket Amount	1,749,182
Patient Liability Reduction due to Other Payer Amount	15,868,623
Covered Drug Plan Paid Amount	243,791,919
Non-Covered Plan Paid Amount	7,878,966
Six Payment Amount Totals	420,293,884
Unknown/Unreconciled	15,836,435

Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and while the patient is under hospice care. For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment unrelated to the terminal illness or related conditions. After a hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, those same drugs may be appropriate to continue as they may offer symptom relief for the palliation and management of the terminal

prognosis.⁵ In our ongoing analysis of non-hospice spending, we remain concerned that common palliative and other disease-specific drugs for hospice beneficiaries that should be covered under the Part A Medicare hospice benefit are instead being covered and paid for through Part D. Based on our own analysis as demonstrated in the data provided above and similar analyses conducted by the Office of the Inspector General (OIG) regarding Part D drug expenditures for Medicare hospice beneficiaries, we believe that Medicare could be paying twice for drugs that are already covered under the hospice per diem payment by also paying for them under Part D.⁶

We continue to expect that hospices should be providing virtually all of the care needed by terminally ill individuals, including related prescription drugs. The comprehensive nature of the services covered under the Medicare hospice benefit is structured such that hospice beneficiaries should not have to routinely seek items, services, and/or medications beyond those provided by hospice. The hospice medical director, the attending physician (if any), and the hospice IDG

⁵ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf>.

⁶ <https://oig.hhs.gov/oas/reports/region6/61000059.asp>, “Medicare Could Be Paying Twice for Prescriptions for Beneficiaries in Hospice.”

determine, on a case-by-case basis, what items and services are related and unrelated to the palliation and management of the terminal illness and related conditions during the admission process, the initial and comprehensive assessments, and in the development of the hospice plan of care (§§ 418.25, 418.54, and 418.56).

To the extent that individuals receive services outside of the Medicare hospice benefit, Medicare coverage is determined by whether or not the services are for the treatment of a condition completely unrelated to the individual's terminal illness and related conditions (48 FR 38148). However, we have presented hospice monitoring data from the past several years, as seen above, that continue to show a non-trivial amount of items, services, and medications being furnished outside of the Medicare hospice benefit to beneficiaries under a hospice election. We encourage hospices to educate beneficiaries regarding the comprehensive nature of the hospice benefit. Although it should be rare, if any conditions are identified by the hospice as unrelated to the terminal illness and related conditions, we further encourage hospices to inform the beneficiary (or representative) at or near the time of election and provide the clinical rationale for such determinations. The regulations at § 476.78 state that providers must inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to Quality Improvement Organization (QIO) review. If a beneficiary disagrees with the hospice determination of what conditions are unrelated to the terminal illness and related conditions (and thus arguably not provided as part of the hospice benefit), we strongly encourage hospices to work to resolve the disagreement with the beneficiary (or representative), taking into consideration his or her wishes, treatment preferences and goals. If a resolution cannot be reached, the beneficiary and the hospice can agree to participate in a flexible, dialogue-based resolution process, called immediate advocacy, which is coordinated by the QIO. We will continue to monitor non-hospice spending during a hospice election and consider ways to address this issue through future regulatory and/or program integrity efforts, if needed.

2. Initial Analysis of Revised Hospice Cost Report Data

a. Background

As mentioned in section II.B of this proposed rule, the Medicare hospice per diem payment amounts were developed to cover all services needed for the palliation and management of the terminal illness and related conditions, as described in section 1861(dd)(1) of the Act. Services provided under a written plan of care could include: Nursing care provided by or under the supervision of a registered professional nurse; physical therapy, occupational therapy, speech-language pathology services; counseling (including dietary counseling); medical social services under the direction of a physician; services of a home health aide; homemaker services; medical supplies (including drugs and biologicals) and the use of durable medical equipment; physician services; short-term inpatient care (including both respite care and care necessary for pain control and acute and chronic symptom management) in a qualified inpatient facility; or any other item or service which has been specified in the plan of care for which payment may be made under Medicare. Under the current payment system, hospices are paid for each day that a beneficiary is enrolled in hospice care, regardless of whether services are rendered on any given day.

As described in the FY 2016 Hospice Wage Index and Payment Rate Update final rule, we finalized changes to the hospice cost report form in order to broaden the scope and detail of data we collect regarding the costs of providing hospice care (80 FR 47150).⁷ We believed that changes were needed to the hospice cost report in order to collect data on the costs of services provided at each level of care, rather than by costs per day, regardless of the level of care. The revisions to the cost report form for freestanding hospices became effective for cost reporting periods beginning on or after October 1, 2014. The instructions for completing the revised freestanding hospice cost report form are found in the Medicare Provider Reimbursement Manual—Part 2, chapter 43.⁸ Medicare-certified institutional providers are required to submit an annual cost report to a Medicare Administrative Contractor

⁷ CMS Transmittal 2864. "Additional Data Reporting Requirements for Hospice Claims", Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf>.

⁸ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1P243.pdf>.

(MAC). The cost report contains provider information such as facility characteristics, utilization data, costs by cost center (for all payers as well as Medicare), Medicare settlement data, and financial statement data.

b. Methodology

Section 1814(i)(6) of the Act, as amended by section 3132(a)(1)(B) of the Affordable Care Act, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The data collected may be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care. Effective October 1, 2014, we finalized changes to the hospice cost report to improve data collection on the costs of providing hospice care. We conducted a preliminary analysis of the new cost report data (CMS Form 1984–14) for freestanding hospices with cost reporting periods in FY 2015, which totaled 2,675 reports. Using this data we calculated preliminary estimates of total costs per day by level of care. It is important to note that the values we computed for cost per day include all payer sources, both Medicare and non-Medicare; however, we believe that the total cost figures represent a reasonable proxy for estimating costs related to the provision of care for Medicare beneficiaries. In order to compute total Medicare-related costs by level of care, we multiplied the computed cost per day by level of care (as reported on Worksheet C) for each hospice by the number of Medicare days by level of care. We then calculated total payments by level of care for each hospice by multiplying the FY 2015 Medicare hospice payments by level of care by the number of Medicare days by level of care. Total costs, payments, and days by level of care were summed for each unique hospice. In order to more accurately account for the hourly CHC cost per day, we used data from Medicare claims in order to quantify the hours of CHC provided by summing the hours of CHC reported in revenue center 0652, which tallies the units of CHC care. We then divided the CHC costs by the number of CHC hours as reported in revenue center 0652 to calculate a CHC per-hour value. In order to mitigate the impact of statistical outliers, we applied trims on the outer bounds of cost per day by level of care, set at the 1st and 99th percentile of the distribution.

c. Overall Payments and Costs and Costs by Level of Care

For the purposes of evaluating calculated costs per day by level of care

compared to Medicare payment amounts, we compared the reported costs on the Medicare cost report to the FY 2015 per diem payment rates by level of care, as follows (79 FR 50485). We note that these amounts were not

adjusted by geographic differences in wage rates and are meant to serve as a general benchmark:

- \$159.34 for RHC
- \$929.91 for 24 hours of CHC (hourly rate of \$38.75)
- \$164.81 for IRC

- \$708.77 for GIP

Table 11 shows the distribution of the calculated Average Cost Per Day by Level of Care, using data from Worksheet C—Rows 3, 8, 13, 18—Column 3.

TABLE 11—SUMMARY STATISTICS: MEDICARE COSTS PER DAY BY LEVEL OF CARE, FY 2015

Level of care	Number of cost reports	Mean	Weighted mean	Minimum value	25th Percentile	Median	75th Percentile	Maximum value	FY2015 per diem payment amounts
CHC cost per day, per hour.	1,088	\$91	\$49	\$4	\$18	\$51	\$95	\$1,853	\$929.91 for 24 hours (\$38.75 hourly rate).
RHC cost per day ..	2,578	133	123	50	105	125	150	399	159.34.
IRC cost per day ...	1,930	632	467	38	221	343	549	17,813	164.81.
GIP cost per day ...	1,782	1,079	792	64	564	879	1,251	10,858	708.77.

Source: Medicare hospice cost report data for FY 2015.

As mentioned above, the data analyzed were trimmed to minimize the effect of statistical anomalies. Nevertheless, there is substantial variation in the reported cost per day by hospices. Total cost per day values in the four levels of care span from a minimum of \$4 to maximum values in the tens of thousands. Because of this wide range of values in the distribution, we used the median as well as the mean values weighted by the number of days by level of care as reference points in these preliminary analyses. When compared with the FY 2015 per diem payment rates, the calculated median and weighted mean costs associated with providing RHC are lower than the base payment rates. As noted in section III.A of this proposed rule, the RHC level of care accounts for over 98 percent of all hospice days based on our analysis of claims for FY 2016. The median and weighted mean costs for the provision of RHC are estimated at \$125 and \$123 respectively, with both figures presenting lower values than the FY 2015 per diem payment rate of \$159.34, a difference of approximately \$35 per day.

Conversely, for CHC the estimated median and weighted mean costs per day, per hour are \$51 and \$49, respectively. The FY 2015 payment rate for CHC was \$38.75 per hour. The CHC level of care accounts for approximately 0.27 percent of all hospice days in FY 2016, as noted in section III.A of this proposed rule. Similarly, the median and weighted mean costs per day associated with the provision of GIP care is estimated at \$879 and \$792, respectively, while the FY 2015 per

diem payment amount for GIP was \$708.77. As noted in section III.A of this proposed rule, the GIP level of care accounts for approximately 1.40 percent of all hospice days based on our analysis of FY 2016 claims. Likewise, the median and weighted mean costs per day associated with the IRC level of care are estimated at \$343 and \$467, respectively, while the per diem payment amount for FY 2015 was \$164.81, and we estimate that IRC days represent approximately 0.31 percent of all hospice days in FY 2016 claims as described in section III.A above.

We recognize that this is the first period in which hospices have supplied cost information on the revised cost report that became effective for cost reporting periods beginning on or after October 1, 2014 and expect that some of the early trends may be the result of hospices learning how to accurately report this information. Therefore, any interpretations regarding the overall alignment between costs and payment would likely be premature given the newness of the data. Moreover, this preliminary analysis did not incorporate factors that merit consideration in future analyses, such as the exclusion of providers surpassing the hospice inpatient and aggregate caps as well as the application of a more robust trimming process to the cost report dataset. As we continue to gather more cost report data, we plan to conduct more thorough analyses of the cost report data and fully assess Medicare-related hospice costs as compared with Medicare hospice payments by level of care. We encourage hospices to continue

to submit the most accurate data possible on Medicare cost reports.

B. Proposed FY 2018 Hospice Wage Index and Rate Update

1. Proposed FY 2018 Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospice agencies under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished. The hospice wage index utilizes the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Our regulations at § 418.306(c) require each labor market to be established using the most current hospital wage data available, including any changes made by OMB to the Metropolitan Statistical Areas (MSAs) definitions.

We use the previous FY's hospital wage index data to calculate the hospice wage index values. For FY 2018, the hospice wage index will be based on the FY 2017 hospital pre-floor, pre-reclassified wage index. This means that the hospital wage data used for the hospice wage index is not adjusted to take into account any geographic reclassification of hospitals including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic area in which the beneficiary resides when receiving routine home care (RHC) or continuous home care (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 general inpatient care (GIP) or Inpatient Respite Care (IRC).

There exist some geographic areas where there were no hospitals, and thus, no hospital wage index data on which to base the calculation of the hospice wage index. In the FY 2008 Hospice Wage Index final rule (72 FR 50214), we implemented a methodology to update the hospice wage index for such areas. In cases where there was a rural area without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous Core-Based Statistical Areas (CBSAs), to represent a reasonable proxy for the rural area. The term "contiguous" means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2018, we propose to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

In the FY 2010 Hospice Wage Index final rule (74 FR 39386), we adopted the policy that for urban labor markets without a hospital from which hospital wage index data could be derived, all of the CBSAs within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2018, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia.

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. Pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a

pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15 which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

On February 28, 2013, OMB issued OMB Bulletin No. 13-01, announcing revisions to the delineation of MSAs, Micropolitan Statistical Areas, and Combines Statistical Areas, and guidance on uses of the delineation in these areas. In the FY 2016 Hospice Wage Index final rule (80 FR 47178), we adopted the OMB's new area delineations using a 1-year transition. In the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47178), we stated that beginning October 1, 2016, the wage index for all hospice payments would be fully based on the new OMB delineations. The most recent bulletin (No. 15-01) concerning the revised delineations was published by the OMB on July 15, 2015.

The proposed hospice wage index applicable for FY 2018 (October 1, 2017 through September 30, 2018) is available on the Web site at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html>.

2. Proposed Hospice Payment Update Percentage

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient market basket percentage increase for that FY. The Act historically required us to use the inpatient hospital market basket as the basis for the hospice payment rate update.

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as

specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP). In addition to the MFP adjustment, section 3401(g) of the Affordable Care Act also mandated that in FY 2013 through FY 2019, the hospice payment update percentage would be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act).

Normally, the proposed hospice payment update percentage for FY 2018 would have been based on the estimated inpatient hospital market basket update of 2.9 percent (based on IHS Global Insight, Inc.'s fourth quarter 2016 forecast with historical data through the third quarter of 2016 of the proposed 2014-based IPPS market basket). Due to the requirements at section 1886(b)(3)(B)(xi)(II) of the Act, the estimated FY 2018 inpatient hospital market basket update of 2.9 percent would have been reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.4 percentage point for FY 2018). Section 1814(i)(1)(C)(v) of the Act requires that the estimated inpatient hospital market basket update for FY 2018 would be reduced further by 0.3 percentage point. In effect, the proposed hospice payment update percentage for FY 2018 would be 2.2 percent. However, section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015, Public Law 114-10 (April 16, 2015) (MACRA) amended section 1814(i)(1)(C) of the Act such that for hospice payments for FY 2018, the market basket percentage increase, after application of the productivity adjustment and the 0.3 percent reduction, if applicable, shall be 1 percent. Therefore, for FY 2018, the hospice payment update percentage will be 1 percent.

Currently, the labor portion of the hospice payment rates is as follows: For RHC, 68.71 percent; for CHC, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. Therefore, the non-labor portion of the payment rates is as follows: For RHC, 31.29 percent; for CHC, 31.29 percent; for General Inpatient Care, 35.99 percent; and for Respite Care, 45.87 percent. Beginning with cost reporting periods starting on or after October 1, 2014, freestanding hospice providers are

required to submit cost data using CMS Form 1984-14 (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospice-2014.html>). We are currently analyzing this data for possible use in updating the labor portion of the hospice payment rates. Any changes to the labor portions will be proposed in future rulemaking and will be subject to public comments.

3. Proposed FY 2018 Hospice Payment Rates

There are four payment categories that are distinguished by the location and intensity of the services provided. The base payments are adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index. A hospice is paid the RHC rate for each day the beneficiary is enrolled in hospice, unless the hospice provides CHC, IRC, or GIP. CHC is provided during a period of patient crisis to maintain the patient at home; IRC is short-term care to allow the usual caregiver to rest and be relieved from caregiving; and GIP is to treat symptoms that cannot be managed in another setting.

As discussed in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 61 and beyond. In addition, in the final rule, we adopted a Service Intensity

Add-on (SIA) payment for RHC for when direct patient care is provided by a RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the day of service, if certain criteria are met. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by a SIA budget neutrality factor.

As discussed in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47177), we will continue to make the SIA payments budget neutral through an annual determination of the SIA budget neutrality factor (SBNF), which will then be applied to the RHC payment rates. The SBNF will be calculated for each FY using the most current and complete FY utilization data available at the time of rulemaking. For FY 2018, we calculated the SBNF using FY 2016 utilization data. We examined skilled nursing and social work visit data for the last 7 days of life where RHC was billed and found that, from January 1 through September 30, 2016, approximately 86 percent of nursing visits were identified as RN visits (using G0299) and 14 percent of nursing visits were identified as LPN visits (using G0300). For skilled nursing visits during the last 7 days of life where RHC was billed and that occurred between October 1 and December 31, 2015, we assumed that 86 percent of the line item

visits reported using G0154 were RN and 14 percent were LPN. For FY 2018, the budget neutrality adjustment that would apply to days 1 through 60 is calculated to be 1.0018. The budget neutrality adjustment that would apply to days 61 and beyond is calculated to be 1.0005.

In the FY 2017 Hospice Wage Index and Payment Rate Update final rule (82 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. In order to calculate the wage index standardization factor, we simulate total payments using the proposed FY 2018 hospice wage index and compare it to our simulation of total payments using the FY 2017 hospice wage index. By dividing payments for each level of care using the proposed FY 2018 wage index by payments for each level of care using the FY 2017 wage index, we obtain a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP). The wage index standardization factors for each level of care are shown in the tables below.

Lastly, the hospice payment rates for hospices that submit the required quality data would be increased by the proposed FY 2018 hospice payment update percentage of 1.0 percent as discussed in section III.B.2. The proposed FY 2018 RHC rates are shown in Table 12. The proposed FY 2018 payment rates for CHC, IRC, and GIP are shown in Table 13.

TABLE 12—PROPOSED FY 2018 HOSPICE RHC PAYMENT RATES

Code	Description	FY 2017 payment rates	SBNF	Wage index standardization factor	FY 2018 proposed hospice payment update	FY 2018 Proposed payment rates
651	Routine Home Care (days 1-60)	\$190.55	× 1.0018	× 1.0000	× 1.01	\$192.80
651	Routine Home Care (days 61+)	\$149.82	× 1.0005	× 1.0001	× 1.01	\$151.41

TABLE 13—PROPOSED FY 2018 HOSPICE CHC, IRC, AND GIP PAYMENT RATES

Code	Description	FY 2017 payment rates	Wage index standardization factor	FY 2018 proposed hospice payment update	FY 2018 proposed payment rates
652	Continuous Home Care	\$964.63	× 1.0022	× 1.01	\$976.42
	Full Rate = 24 hours of care				
	\$40.68 = FY 2018 hourly rate				
655	Inpatient Respite Care	170.97	× 1.0006	× 1.01	172.78
656	General Inpatient Care	734.94	× 1.0017	× 1.01	743.55

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit

quality data, based on measures to be specified by the Secretary. In the FY

2012 Hospice Wage Index final rule (76 FR 47320 through 47324), we

implemented a Hospice Quality Reporting Program (HQRP) as required by section 3004 of the Affordable Care Act. Hospices were required to begin collecting quality data in October 2012, and submit that quality data in 2013. Section 1814(i)(5)(A)(i) of the Act

requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. The proposed FY

2018 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2018 hospice payment update percentage of 1 percent minus 2 percentage points. These rates are shown in Tables 14 and 15.

TABLE 14—PROPOSED FY 2018 HOSPICE RHC PAYMENT RATES FOR HOSPICES THAT *DO NOT* SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2017 payment rates	SBNF	Wage index standardization factor	FY 2018 proposed hospice payment update of 1% minus 2 percentage points = -0.1%	FY 2018 proposed payment rates
651	Routine Home Care (days 1–60)	\$190.55	× 1.0018	× 1.0000	× 0.99	\$188.98
651	Routine Home Care (days 61+)	\$149.82	× 1.0005	× 1.0001	× 0.99	148.41

TABLE 15—PROPOSED FY 2018 HOSPICE CHC, IRC, AND GIP PAYMENT RATES FOR HOSPICES THAT *DO NOT* SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2017 payment rates	Wage index standardization factor	FY 2018 proposed hospice payment update	FY 2018 Proposed payment rates
652	Continuous Home Care	\$964.63	× 1.0022	× 0.99	\$957.08
	Full Rate = 24 hours of care \$39.88 = FY 2018 hourly rate				
655	Inpatient Respite Care	\$170.97	× 1.0006	× 0.99	\$169.36
656	General Inpatient Care	734.94	× 1.0017	× 0.99	728.83

4. Hospice Cap Amount for FY 2018

As discussed in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47183), we implemented changes mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Specifically, for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the consumer price index for urban consumers (CPI-U). The hospice cap amount for the 2018 cap year will be \$28,689.04, which is equal to the 2017 cap amount (\$28,404.99) updated by the FY 2018 hospice payment update percentage of 1.0 percent.

C. Discussion and Solicitation of Comments Regarding Sources of Clinical Information for Certifying Terminal Illness

Hospice provides relief from pain and symptoms, provides psychosocial and spiritual comfort, and allows an individual to die with dignity and surrounded by family and friends. Despite the invaluable support hospices offer, it is not an easy decision and not

one individuals generally arrive at on their own. Election of hospice is a significant decision and one which patients and their physicians do not take lightly, as it involves a shift in traditional health care philosophy from curative to palliative care. In general, the majority of hospice referrals do come from family physicians who have often cared for patients with chronic illnesses for long periods of time.⁹ These providers are in the unique position of understanding and identifying the individualized progression of the patient’s illness and recognizing when the condition becomes terminal. To be eligible to elect the Medicare hospice benefit, the individual must have Medicare Part A and be certified as terminally ill as articulated at § 418.20. The regulations define “terminally ill” to mean that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course (§ 418.3). The regulations at § 418.22(c) require that for the initial 90-

⁹Michelle T. Weckmann, MD, MS, University of Iowa Hospitals and Clinics, Iowa *The Role of the Family Physician in the Referral and Management of Hospice Patients*. Am Fam Physician, 2008 Mar 15;77(6):807–812.

day period of hospice care, the hospice must obtain written certification statements from the medical director of the hospice or the physician member of the hospice interdisciplinary group, and the individual’s attending physician, if the individual has an attending physician. The current regulations at § 418.25(b) state that in reaching a decision to certify, the hospice medical director, or hospice physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient’s life expectancy is 6 months or less if the illness runs its normal course. These regulations require that the hospice medical director consider at least the following information:

1. Diagnosis of the terminal condition of the patient.
2. Other health conditions, whether related or unrelated to the terminal condition.
3. Current clinically relevant information supporting all diagnoses.

The admission requirements at § 418.22(b)(2) require that this clinical information and other documentation that supports the medical prognosis must accompany the certification and be filed in the medical record with the

written certification. Whereas the regulations at § 418.25(b) provide the type of clinical information the hospice medical director or hospice physician designee must consider in the certification of terminal illness, the source of this clinical information is not clearly identified. This raises the question as to what clinical information the hospice medical director (or hospice physician designee) is relying on to support his or her certification that the individual is terminally ill and from where this information was obtained.

Multiple clinical tools and guidelines, and more specifically the Medicare Administrative Contractor (MAC) Local Coverage Determinations (LCDs), exist to assist the patient-designated attending physician and hospice medical director/hospice physician designee in determining the patient's terminal prognosis. These guidelines provide indicators that support a decline in clinical status, including, but not limited to: History of recurrent infections, worsening symptoms that are non-responsive to treatment, increasing emergency department and clinician visits, laboratory results supporting progression of disease, and change in functional status.¹⁰ However, documentation of these indicators would likely not exist without some degree of long-term monitoring and evaluation by a physician separate from the hospice medical director/hospice physician designee. As such, this information would typically be found in the referring physician's and/or acute/post-acute care facility's medical records.

Understandably, many family physicians typically take on the role of the attending physician once the patient chooses to elect hospice. They have played an invaluable role in coordinating care throughout the spectrum of the patient's life, and as such, have in depth "knowledge of the patient's values, family issues, and communication style."¹¹ However, in accordance with our regulation at § 418.22(c)(1)(ii), only the initial certification has to involve the attending physician and only IF the patient has designated one. There is currently no requirement that a patient must designate an attending physician and therefore the responsibility for certification can solely reside with the hospice medical director or the

physician member of the hospice interdisciplinary group. Furthermore, this regulation does not require that the hospice medical director or physician member of the hospice interdisciplinary group designee has a face-to-face encounter with the patient when initially certifying the patient as terminally ill. Rather, a face-to-face encounter with a hospice physician or allowed non-physician practitioner is not required until the third election period and each subsequent recertification thereafter. Consequently, a patient may never be seen by the hospice physician who is certifying that he or she is terminally ill.

No visits to the patient are covered under the Medicare hospice benefit until the individual has been certified as terminally ill, an election statement has been signed, and a plan of care has been established (§ 418.200). Therefore, any information regarding the patient's health status from hospice staff (for example, registered nurses) should not be the sole documentation used to support the initial certification requirement as the patient has yet to meet the eligibility requirement. Because Medicare hospice coverage depends on being certified as terminally ill and requires an individual to waive rights to Medicare payment for services for the terminal illness and related conditions, except when provided by the designated hospice or attending physician, the expectation is that the hospice physician certifying terminal illness will be thorough and accountable in his review of clinical information. As discussed in the 1983 final rule "Medicare Program; Hospice Care", "written certification is the only true assurance that the patient's condition has been assessed at or before the time of admission to a hospice program" (48 FR 56010). This is important to both the hospice who will be assuming virtually all of the care needs of the terminally ill individual and to the patient, who must have a thorough basis for his or her decision to elect hospice rather than continue curative care.

There are ongoing concerns that some hospice patients may be inappropriately certified as terminally ill. Operation Restore Trust (ORT), an anti-fraud and abuse initiative by the Department of Health and Human Services Office of Inspector General (OIG) to identify vulnerabilities in the Medicare program and to pursue ways to reduce Medicare's exposure to fraud and abuse, identified several areas of weakness in the hospice benefit, primarily in the area of hospice eligibility. Specifically, it uncovered instances of insufficient hospice documentation and

inappropriately reported diagnoses.⁴ In 1995, in response to ORT's initial report, CMS issued program memoranda requiring submission of clinical information and other documentation that supports the medical prognosis. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 amended section 1814(a) of the Social Security Act (The Act) clarifying that certification is based on the physician or medical director's clinical judgment. Regardless, subsequent ORT reports and CMS Regional Offices and Regional Home Health Intermediary (now called Medicare Administrative Contractors) reviews continued to raise concerns regarding inappropriate certifications, specifically, certifications made for patients who are chronically ill, but who are without complications or other circumstances that indicate a life expectancy of 6 months or less.¹²

In response to those concerns, the "Medicare Program; Hospice Care Amendments" proposed rule (67 FR 70363, November 22, 2002), which proposed the implementation of revisions required by the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to the existing regulations at the time governing coverage and payment for hospice care under the Medicare program, proposed revisions to § 418.22, *Certification of Terminal Illness*, requiring that specific clinical findings and other documentation supporting the medical prognosis accompany the written certification and be filed in the hospice medical record. Additionally, the 2002 rule proposed adding § 418.25 *Admission to Hospice Care*, which established general guidance on hospice admission procedures. These changes acknowledged that "the amendment regarding the physician's clinical judgment does not negate the fact that there must be a basis for certification" and that "a mere signed certification, absent a medically sound basis that supports the clinical judgment, is not sufficient for application of the hospice benefit under Medicare." Ultimately, the final rule, "Medicare Program; Hospice Care Amendments" (70 FR 70532, November 22, 2005) codified the requirements and the expectations about the clinical information needed to

¹⁰ <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx>.

¹¹ Michelle T. Weckmann, MD, MS, University of Iowa Hospitals and Clinics, Iowa City, Iowa *The Role of the Family Physician in the Referral and Management of Hospice Patients*. Am Fam Physician, 2008 Mar 15;77(6):807-812.

¹² Department of Health and Human Services: Office of the Inspector General. *Operation Restore Trust Activities* by June Gibbs Brown, IG. November 1995.

support the certification of a medical prognosis of 6 months or less at § 418.22 (70 FR 70538). The final rule also set out the specific admission requirements indicating that the hospice medical director along with the patient's attending physician, if any, is responsible for admitting the patient, and identifies what information he or she must consider when certifying a patient as terminally ill (§ 418.25).

Additionally, the Medicare Payment Advisory Commission's (MedPAC) March 2009 report entitled "Report to the Congress: Medicare's Payment Policy" noted specific concerns regarding trends towards an increasing proportion of hospice patients with stays exceeding 180 days.¹³ An analysis of this trend by a hospice expert panel illuminated limited medical director engagement in the certification or recertification process as a possible cause of this utilization pattern, reviving concerns that patients were again being inappropriately certified as terminally ill and were not actually eligible to elect the benefit. The panel determined that "physicians responsible for certifying and recertifying a patient's eligibility for hospice may inappropriately delegate much of this responsibility to other parties." In response to these concerns, we finalized a policy requiring that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis. The FY 2010 Hospice Wage Index final rule (74 FR 39398) codified this narrative requirement for the certification of terminal illness at § 418.22(b)(3), in order to increase accountability and add oversight to the physician certification/recertification process.

In the "Medicare Program; Hospice Wage Index and Payment Rate Update FY 2015" final rule (79 FR 50470), we again provided guidance on determining beneficiaries' eligibility for hospice, reiterating that the hospice "is required to make certain that the physician's clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of a life expectancy of 6 months or less if the illness runs its normal course." This discussion reinforced the importance of ensuring that hospices are thorough in their eligibility determinations so that hospice beneficiaries are able to access all of their Medicare benefits

appropriately and added additional oversight to the physician certification and recertification process. The inherent challenges in prognostication make it critical for a hospice to obtain, and the certifying hospice medical director or hospice physician designee to comprehensively review, the patient's clinical information when making the determination that the patient is terminally ill, and thus eligible for the Medicare hospice benefit. By increasing physician engagement and accountability, patients can be assured they are making the most informed decision possible, without limiting their treatment choices. In the FY 2006 Hospice Wage Index final rule (70 FR 70538), we received comments stating that it is common practice for hospices to obtain clinical information from the referring physician, which is then documented in the patient's hospice medical record.

Accordingly, we are soliciting comments for possible future rulemaking, on amending the regulations at § 418.25 to specify that the referring physician's and/or the acute/post-acute care facility's medical record would serve as the basis for initial hospice eligibility determinations. Clinical information from the referring physician and/or acute/post-acute care facility supporting a terminal prognosis would be obtained by the hospice prior to election of the benefit, when determining certification and subsequent eligibility. This potential clarifying regulatory text change would be in alignment with benefit eligibility criteria that the individual must be certified as terminally ill prior to receiving hospice services, and fundamentally could not be determined by hospice documentation obtained after admission. We are also soliciting comments on amending the regulations text at § 418.25 to specify that documentation of an in-person visit from the hospice Medical Director or the hospice physician member of the interdisciplinary group could be used as documentation to support initial hospice eligibility determinations, only if needed to augment the clinical information from the referring physician/facility's medical records. Comments on current processes used by hospices to ensure comprehensive clinical review to support certification and any alternate suggestions for supporting clinical documentation sources are also encouraged.

D. Proposed Updates to the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

Section 3004(c) of the Affordable Care Act amended section 1814(i)(5) of the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points could result in the annual market basket update being less than 0 percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the particular year involved. Any such reduction would not be cumulative or be taken into account in computing the payment amount for subsequent FYs. Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form, manner, and at a time specified by the Secretary.

2. General Considerations Used for Selection of Quality Measures for the HQRP

Any measures selected by the Secretary must be endorsed by the consensus-based entity, which holds a contract regarding performance measurement, including the endorsement of quality measures, with the Secretary under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). However, section 1814(i)(5)(D)(ii) of the Act provides that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus-based entity, the Secretary may specify measures that are not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary. Our paramount concern is the successful development of a HQRP that promotes the delivery of high quality healthcare services. We seek to adopt measures for the HQRP that promote person-centered, high quality, and safe care. Our measure selection activities for the HQRP take into consideration

¹³ Medicare Payment Advisory Commission. *Report to the Congress: Medicare's Payment Policy*. Washington, DC, March 2009. Accessed on March 31, 2017 at: <http://www.medpac.gov/docs/default-source/reports/march-2009-report-to-congress-medicare-payment-policy.pdf?sfvrsn=0>.

input from the Measure Applications Partnership (MAP), convened by the NQF, as part of the established CMS pre-rulemaking process required under section 1890A of the Act. The MAP is a public-private partnership comprised of multi-stakeholder groups convened by the NQF for the primary purpose of providing input to CMS on the selection of certain categories of quality and efficiency measures, as required by section 1890A(a)(3) of the Act. By February 1st of each year, the NQF must provide that input to CMS. Input from the MAP is located at: http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx. We also take into account national priorities, such as those established by the HHS Strategic Plan (<http://www.hhs.gov/secretary/about/priorities/priorities.html>), the National Strategy for Quality Improvement in Healthcare, (<http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2015annlrpt.htm>) and the CMS Quality Strategy (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>). To the extent practicable, we have sought to adopt measures endorsed by member organizations of the National Consensus Project (NCP) (<http://www.nationalconsensusproject.org/Default.aspx>), recommended by multi-stakeholder organizations, and developed with the input of providers, purchasers/payers, and other stakeholders.

We consider related factors that may affect measures in the HQR. We understand that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support (certain factors of which are also sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors) play a major role in health. One of our core objectives is to improve beneficiary outcomes including reducing health disparities, and we want to ensure that all beneficiaries, including those with social risk factors, receive high quality care. In addition, we seek to ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible under our programs while ensuring that beneficiaries have adequate access to excellent care.

We have been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation

(ASPE)¹⁴ and the National Academies of Sciences, Engineering, and Medicine on the issue of measuring and accounting for social risk factors in CMS' value-based purchasing and quality reporting programs, and considering options on how to address the issue in these programs. On December 21, 2016, ASPE submitted a Report to Congress on a study it was required to conduct under section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The study analyzed the effects of certain social risk factors of Medicare beneficiaries on quality measures and measures of resource use used in one or more of nine Medicare value-based purchasing programs.¹⁵ The report also included considerations for strategies to account for social risk factors in these programs. In a January 10, 2017 report released by The National Academies of Sciences, Engineering, and Medicine, that body provided various potential methods for measuring and accounting for social risk factors, including stratified public reporting.¹⁶

In addition, the NQF has undertaken a 2-year trial period in which new measures, measures undergoing maintenance review, and measures endorsed with the condition that they enter the trial period can be assessed to determine whether risk adjustment for selected social risk factors is appropriate for these measures. This trial entails temporarily allowing inclusion of social risk factors in the risk-adjustment approach for these measures. At the conclusion of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for quality measures.

As we continue to consider the analyses and recommendations from these reports and await the results of the NQF trial on risk adjustment for quality measures, we are continuing to work with stakeholders in this process. As we have previously communicated, we are concerned about holding providers to different standards for the outcomes of their patients with social risk factors because we do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations. Keeping

¹⁴ <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>.

¹⁵ <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>.

¹⁶ National Academies of Sciences, Engineering, and Medicine. 2017. Accounting for social risk factors in Medicare payment. Washington, DC: The National Academies Press.

this concern in mind, while we sought input on this topic previously, we continue to seek public comment on whether we should account for social risk factors in measures in the HQR, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors. Examples of methods include: Confidential reporting to providers of measure rates stratified by social risk factors, public reporting of stratified measure rates, and potential risk adjustment of a particular measure as appropriate based on data and evidence.

In addition, we are also seeking public comment on which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure. Examples of social risk factors include, but are not limited to, dual eligibility/low-income subsidy, race and ethnicity, and geographic area of residence. We are seeking comments on which of these factors, including current data sources where this information would be available, could be used alone or in combination, and whether other data should be collected to better capture the effects of social risk. We will take commenters' input into consideration as we continue to assess the appropriateness and feasibility of accounting for social risk factors in the HQR. We note that any such changes would be proposed through future notice and comment rulemaking.

We look forward to working with stakeholders as we consider the issue of accounting for social risk factors and reducing health disparities in our programs. Of note, implementing any of the above methods would be taken into consideration in the context of how this and our other programs operate (for example, data submission methods, availability of data, statistical considerations relating to reliability of data calculations, among others), so we also welcome comment on operational considerations. We are committed to ensuring that its beneficiaries have access to and receive excellent care, and that the quality of care furnished by providers and suppliers is assessed fairly in our programs.

3. Policy for Retention of HQR Measures Adopted for Previous Payment Determinations

For the purpose of streamlining the rulemaking process, we finalized our policy in the FY 2016 Hospice Wage Index final rule (80 FR 47187) that when we adopt measures for the HQR beginning with a payment determination year, these measures

would automatically be adopted for all subsequent years' payment determinations, unless we proposed to remove, suspend, or replace the measures. Quality measures would be considered for removal by us for reasons including, but not limited to:

- Measure performance among hospices was so high and unvarying that meaningful distinction in improvements in performance could no longer be made;
- Performance or improvement on a measure did not result in better patient outcomes;
- A measure did not align with current clinical guidelines or practice;
- A more broadly applicable measure (across settings, populations, or conditions) for the particular topic was available;
- A measure that was more proximal in time to desired patient outcomes for the particular topic was available;
- A measure that was more strongly associated with desired patient outcomes for the particular topic was available; or
- Collection or public reporting of a measure led to negative unintended consequences.

For any such removal, the public would be given an opportunity to comment through the annual rulemaking process. However, if there was reason to believe continued inclusion of a measure in the HQRP would encourage delivery of care that raised potential safety concerns, we would take immediate action to remove the measure from the HQRP and not wait for the annual rulemaking cycle. The measures would be promptly removed and we would immediately notify hospices and the public of such a decision through the CMS HQRP Web site, listserv messages via the Post-Acute Care QRP listserv,¹⁷ MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews. Following immediate removal of the measures, we would also notify the public of any such removal in the next annual rulemaking cycle. CMS expects immediate removal of a measure due to safety concerns to be an unlikely event, given the rigorous testing and analysis all measures undergo prior to adoption in the HQRP.

4. Policy for Adopting Changes to Previously Adopted Measures

To further streamline the rulemaking process, we finalized in the FY 2017 Hospice Wage Index final rule that if measures in the HQRP undergo non-

substantive changes in specifications as part of their NQF re-endorsement process, we would subsequently utilize the measure with their new endorsed status in the HQRP without going through new notice-and-comment rulemaking (81 FR 52159). As mentioned previously, quality measures selected for the HQRP must be endorsed by the NQF unless they meet the statutory criteria for exception under section 1814(i)(5)(D)(ii) of the Act. The NQF is a voluntary consensus standard-setting organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other healthcare stakeholder organizations. The NQF was established to standardize healthcare quality measurement and reporting through its consensus measure development process (http://www.qualityforum.org/About_NQF/Mission_and_Vision.aspx). The NQF undertakes review of: (a) New quality measures and national consensus standards for measuring and publicly reporting on performance, (b) regular maintenance processes for endorsed quality measures, (c) measures with time-limited endorsement for consideration of full endorsement, and (d) ad hoc review of endorsed quality measures, practices, consensus standards, or events with adequate justification to substantiate the review. Through NQF's or the measure steward's measure maintenance process, measures are sometimes updated to incorporate changes that we believe do not substantively change the intent of the measure. Examples of such changes may include updated diagnosis or procedure codes or changes to exclusions to the patient population or definitions. While we address such changes on a case-by case basis, we generally believe these types of maintenance changes are distinct from substantive changes to measures that result in what are considered new or different measures. Additionally, since the NQF endorsement and measure maintenance process is one that ensures transparency, public input, and discussion among representatives across the healthcare enterprise,¹⁸ we believe that the NQF measure endorsement and maintenance process itself is transparent, scientifically rigorous, and provides opportunity for public input. Thus, we finalized our proposal to codify at § 418.312 that if the NQF makes only non-substantive changes to specifications for HQRP measures in the

NQF's re-endorsement process, we would continue to utilize the measure in its new endorsed status (81 FR 52159 through 52160). If NQF-endorsed specifications change and we do not adopt those changes, then we would propose the measure as a modification. A modification of a NQF-endorsed quality measure is utilized in instances when we have identified a need to use a NQF-endorsed measure in a QRP but need to use it with one or more modifications to the quality measure's specifications. These modifications pertain to, but are not limited to, one or more of the following aspects of a NQF-endorsed quality measure: (a) Numerator, (b) denominator, (c) setting, (d) look-back period, (e) calculation period, (f) risk adjustment, and (g) revisions to data elements used to collect the data required for the measure, etc. CMS may adopt a quality measure for the HQRP under section 1814(i)(5)(D)(ii) of the Act, which states, "[i]n the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by [the NQF], the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary." Reasons for not adopting changes in measure specifications to a measure may include any of the aforementioned criteria in the prior section, including that the new specification does not align with clinical guidelines or practice or that the new specification leads to negative unintended consequences.

Finally, we will continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures we have adopted for the HQRP. We continue to make these determinations about what constitutes a substantive versus non-substantive change on a measure-by-measure basis. A change would be deemed substantive if the intent of the measure changes, the facility/setting changes, the data sources changes, the level of analysis changes, and/or the measure is removed. We will continue to provide updates about changes to measure specifications as a result of NQF endorsement or maintenance processes through the CMS HQRP Web site, listserv messages on the Post-Acute Care QRP listserv, MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews and announcements on Open Door Forums and Special Open Door Forums.

¹⁷ CMS, Post-Acute Care QRP listserv, available at: https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_12265.

¹⁸ "NQF: How Endorsement Happens—National Quality Forum." 2010. 26 Jan. 2016 http://www.qualityforum.org/Measuring_Performance/ABCs/How_Endorsement_Happens.aspx.

5. Previously Adopted Quality Measures for FY 2018 Payment Determination and Future Years

In the FY 2014 Hospice Wage Index final rule (78 FR 48257), and in compliance with section 1814(i)(5)(C) of the Act, we finalized the specific collection of data items that support the following 7 NQF-endorsed measures for hospice:

- NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen,
- NQF #1634 Pain Screening,
- NQF #1637 Pain Assessment,
- NQF #1638 Dyspnea Treatment,
- NQF #1639 Dyspnea Screening,
- NQF #1641 Treatment Preferences,
- NQF #1647 Beliefs/Values Addressed (if desired by the patient).¹⁹

We finalized the following two additional measures in the FY 2017 Hospice Wage Index final rule effective April 1, 2017. Data collected will, if not reported, affect payments for FY 2019 and subsequent years. (81 FR 52163 through 52173):

- Hospice Visits when Death is Imminent
- Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

We finalized the HIS effective July 1, 2014 (78 FR 48258). The HIS is the data collection mechanism for all of the aforementioned measures. To meet the quality reporting requirements for hospices for the FY 2016 payment determination and each subsequent year, we require regular and ongoing electronic submission of the HIS data for each patient admission to hospice after July 1, 2014, regardless of payer or patient age (78 FR 48234 through 48258). For the two measures finalized in the FY 2017 Hospice Wage Index final rule, we require regular and

ongoing electronic submission for each patient admission to hospice after April 1, 2017. We finalized a requirement in the FY 2014 Hospice Wage Index final rule (78 FR 48258) that hospice providers collect data on all patients to ensure that all patients regardless of payer or patient age are receiving the same care and that provider metrics measure performance across the spectrum of patients. Table 16 below provides a summary of measures previously finalized affecting the FY 2019 APU, data collection mechanism, and data submission deadline.

Hospices are required to complete and submit a HIS-Admission and a HIS-Discharge record for each patient admission. Hospices failing to report quality data via the HIS for patient admissions occurring in 2017 will have their market basket update reduced by 2 percentage points in FY 2019 (beginning in October 1, 2018). In the FY 2015 Hospice Wage Index final rule (79 FR 50485 through 50487), we finalized the proposal to codify the HIS submission requirement at § 418.312. The System of Record (SOR) Notice titled “Hospice Item Set (HIS) System,” SOR number 09–70–0548, was published in the **Federal Register** on April 8, 2014 (79 FR 19341).

The 7 NQF endorsed HIS measures adopted in FY 2014 Hospice Wage Index final rule successfully underwent NQF Endorsement Maintenance in 2016.²⁰ We recognize that the NQF endorsement process is an important part of measure development and plan to submit the two measures finalized in the FY 2017 Hospice Wage Index final rule for NQF endorsement once sufficient measure data are available and we conduct the analyses necessary to support NQF submission for endorsement (for example, reliability and validity analyses). Typically, we

need at least 4 quarters worth of data to conduct the necessary analyses and establish measure reliability and validity. Because the Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission did not require any new data collection and can be calculated using existing data, CMS’s measure development contractor, RTI International, has already conducted the analyses necessary to support submission of the measure for NQF endorsement. We have already submitted the Hospice and Palliative Care Composite Process Measure for consideration for endorsement at NQF (NQF #3235); the measure is currently under review. Data for the Hospice Visits when Death is Imminent measure pair will be collected using new items added to the HIS V2.00.0, effective April 1, 2017. Once data collection for the measure pair begins, we will need at least 4 quarters of reliable data to conduct the necessary analyses to support submission to NQF. We will also need to assess the quality of data submitted in the first quarter of item implementation to determine whether they can be used in the analyses. Pending analysis, we will submit the Hospice Visits when Death is Imminent measure pair to NQF for endorsement review in accordance with NQF project timelines and call for measures. In the FY 2015 Hospice Wage Index final rule (79 FR 50491 through 50496), we also finalized the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey to support quality measures based on patient and family experience of care. We refer readers to section III.D.11 of this notice of proposed rulemaking for details regarding the CAHPS® Hospice Survey, including public reporting of selected survey measures.

TABLE 16—PREVIOUSLY FINALIZED QUALITY MEASURES AFFECTING THE FY 2019 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

NQF No.	Measure name	Payment determination (APU) year for which the quality measure was first adopted	Data collection mechanism	Data submission deadline
1641	Treatment Preferences	FY 2016	Hospice Item Set	Rolling—within 30 days of patient admission or discharge (event date).
1647	Beliefs/Values Addressed (if desired by the patient).	FY 2016.		
1634	Pain Screening	FY 2016.		
1637	Pain Assessment	FY 2016.		

¹⁹ Previously finalized as a “modified measure” in the FY17 and prior rules (81 FR 52160). Following NQF maintenance endorsement, NQF #1647 measure specifications were updated and

now aligns with the measure data lookback period for this program.

²⁰ National Quality Forum, *NQF Palliative and End-of-Life Care 2015–2016 Report*, available at:

<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=84242>.

TABLE 16—PREVIOUSLY FINALIZED QUALITY MEASURES AFFECTING THE FY 2019 PAYMENT DETERMINATION AND SUBSEQUENT YEARS—Continued

NQF No.	Measure name	Payment determination (APU) year for which the quality measure was first adopted	Data collection mechanism	Data submission deadline
1639	Dyspnea Screening	FY 2016.		
1638	Dyspnea Treatment	FY 2016.		
1617	Patients Treated with an Opioid Who Are Given a Bowel Regimen.	FY 2016.		
N/A	Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission.	FY 2019	Rolling—within 30 days of patient admission or discharge (event date) for patient admissions to hospice on 04/01/2017 and onward.
N/A	Hospice Visits When Death is Imminent Measure Pair.	FY 2019.		

6. Proposed Removal of Previously Adopted Measures

We are not proposing to remove any of the current HQRP measures at this time. Any future proposals regarding removal, suspension, or replacement of measures will be proposed in this section of future rules. As stated in section III.D.3, a quality measure that is adopted and implemented in the HQRP will be retained for all subsequent years, unless the measure is proposed for removal, suspension, or replacement by CMS. Policies and criteria for removing a measure include those identified in section III.D.3 of this proposed rule.

7. Measure Concepts Under Consideration for Future Years

Although we are not proposing any HIS-based measures in this proposed rule, we have measure concepts under consideration for future years.

Our paramount concern is to develop quality measures that promote care that is person-centered, high quality, and safe. We continue to work with our measure development contractor, RTI International, to identify measure concepts for future implementation in the HQRP. In identifying priority areas for future measure enhancement and development, we take into consideration input from numerous stakeholders, including the MAP, the MedPAC, Technical Expert Panels (TEP), and national priorities, such as those established by the HHS Strategic Plan, the National Strategy for Quality Improvement in Healthcare, and the CMS Quality Strategy. In addition, we take into consideration vital feedback and input from research published by our payment reform contractor. The current HQRP measure set is also an important consideration for future measure development areas; future measure development areas should

complement the current HQRP measure set, including current HIS measures and CAHPS® Hospice Survey measures, without creating unnecessary burden or redundant reporting. Based on input from stakeholders, we identified two high priority areas that will be addressed by claims-based measure development. Developing quality measures using claims does not require new data collection, thus minimizing provider burden and expediting implementation.

• Priority Area 1: Potentially Avoidable Hospice Care Transitions

The concept of a claims-based measure focusing on transitions of care was first introduced in the FY 2016 Hospice Wage Index final rule (80 FR 47188 through 47189). Comments received during this rule were overall supportive of our efforts to develop more robust quality measures that capture hospice performance and show links to patient and family outcomes. We refer readers to the FY 2016 Hospice Wage Index final rule (80 FR 47188 through 47189) for additional detail: <https://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-19033.pdf>.

Potentially avoidable hospice care transitions at end of life are burdensome to patients, families, and the health care system at large, because they are associated with adverse health outcomes, lower patient and family satisfaction, higher health care costs, and fragmentation of care delivery.^{21 22 23 24 25} By encouraging

²¹ Aldridge MDP, MBA; Epstein, Andrew J. Ph.D.; Brody, Abraham A. RN, Ph.D.; Lee, Eric J. MPH; Cherlin, Emily Ph.D., MSW; Bradley, Elizabeth H. Ph.D. The Impact of Reported Hospice Preferred Practices on Hospital Utilization at the End of Life Medical Care. 2016;54(7):657–663.

²² Wang S-Y, Aldridge MD, Gross CP, et al. Transitions Between Healthcare Settings of Hospice

hospice providers to assess and manage patients’ risk of care transitions, this measure concept has the potential to improve quality care at the end of life by reducing potentially avoidable hospice care transitions.

• Priority Area 2: Access to Levels of Hospice Care

The Medicare Hospice Benefit covers four levels of care to meet patients’ and families’ clinical needs: Routine home care (RHC), continuous home care (CHC), general inpatient care (GIP), and inpatient respite care. The goal of this measure concept is to assess the rates at which hospices provide different levels of hospice care. The measure has the potential to improve access to various levels of care for patients and caregivers. Appropriate use of CHC and GIP increases the likelihood of a hospice patient dying in his or her location of choice, decreases health resource utilization resulting in potential cost savings, and increases patient and caregiver satisfaction.^{26 27} Measuring use of levels of care will incentivize hospice providers to continuously assess patient

Enrollees at the End of Life. Journal of the American Geriatrics Society. 2016;64(2):314–322.

²³ Carlson MDA, Herrin J, Du Q, et al. Impact of Hospice Disenrollment on Health Care Use and Medicare Expenditures for Patients With Cancer. Journal of Clinical Oncology. 2010;28(28):4371–4375.

²⁴ Teno JM, Bowman J, Plotzke M, et al. Characteristics of Hospice Programs With Problematic Live Discharges. Journal of Pain and Symptom Management. 2015;50(4):548–552.

²⁵ Prsic E, Plotzke M, Christian TJ, Gozalo P, Teno JM. A National Study of Live Hospice Discharges between 2000 and 2012. Journal of Palliative Medicine. 2016;19(9):987–990.

²⁶ Barclay, J., et al., Association of hospice patients’ income and care level with place of death. JAMA Internal Medicine. 2013. 173(6): p. 450–456.

²⁷ Casarett, D., et al., Does Continuous Hospice Care Help Patients Remain at Home? Journal of Pain and Symptom Management, 2015. 50(3): p. 297–304.

and caregiver needs and provide the appropriate level of care to meet these needs.

These two measure concepts are under development, and details regarding measure definitions, specifications and timeline for implementation will be communicated in future rulemaking. We are soliciting comments regarding high priority concept areas for future measure development.

8. Form, Manner, and Timing of Quality Data Submission

a. Background

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act requires that beginning with the FY 2014 and for each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

b. Policy for New Facilities To Begin Submitting Quality Data

In the FY 2015 Hospice Wage Index final rule (79 FR 50488), we finalized a policy stating that any hospice that receives its CMS Certification Number (CCN) (also known as the Medicare Provider Number) notification letter dated on or after November 1 of the preceding year involved is excluded from any payment penalty for quality reporting purposes for the following FY. This requirement was codified at § 418.312.

In the FY 2016 Hospice Wage Index final rule (80 FR 47189), we further clarified and finalized our policy for the timing of new providers to begin reporting data to CMS. The clarified policy finalized in the FY 2016 Hospice Wage Index final rule (80 FR 47189) distinguished between when new hospice providers are required to begin submitting HIS data and when providers will be subject to the potential 2 percentage point annual payment update (APU) reduction for failure to comply with HQRP requirements. In summary, the policy finalized in the FY 2016 Hospice Wage Index final rule (80 FR 47189 through 47190) clarified that providers must begin submitting HIS data on the date listed in the letterhead of the CCN Notification letter received from CMS but will be subject to the APU reduction based on whether the CCN Notification letter was dated before

or after November 1 of the reporting year involved. Thus, beginning with the FY 2018 payment determination and for each subsequent payment determination, we finalized our policy that a new hospice be responsible for HQRP quality data submission beginning on the date of the CCN notification letter; we retained our prior policy that hospices not be subject to the APU reduction if the CCN notification letter was dated after November 1 of the year involved. For example, if a provider receives their CCN notification letter and the date in the letterhead is November 5, 2017, that provider will begin submitting HIS data for patient admissions occurring after November 5, 2017. However, since the CCN notification letter was dated after November 1st, they would not be evaluated for, or subject to any payment penalties for, the relevant FY APU update (which in this instance is the FY 2019 APU, which is associated with patient admissions occurring January 1, 2017 through December 31, 2017).

This policy allows us to receive HIS data on all patient admissions on or after the date a hospice receives their CCN notification letter, while at the same time allowing hospices flexibility and time to establish the necessary accounts for data submission before they are subject to the potential APU reduction for a given reporting year. Currently, new hospices may experience a lag between Medicare certification and receipt of their actual CCN Number. Since hospices cannot submit data to the QIES ASAP system without a valid CCN Number, we finalized that new hospices begin collecting HIS quality data beginning on the date noted on the CCN notification letter. We believe this policy provides sufficient time for new hospices to establish appropriate collection and reporting mechanisms to submit the required quality data to CMS. Requiring quality data reporting beginning on the date listed in the letterhead of the CCN notification letter aligns our policy requirements for new providers with the functionality of the HIS data submission system (QIES ASAP).

c. Previously Finalized Data Submission Mechanisms, Timelines, and Deadlines

In the FY 2015 Hospice Wage Index final rule (79 FR 50486), we finalized our policy requiring that hospices complete and submit HIS records for all patient admissions to hospice after July 1, 2014. For each HQRP program year, we require that hospices submit data on each of the adopted measures in accordance with the reporting requirements specified in sections

III.C.9.b through III.C.9.c of the FY 2015 rule for the designated reporting period. This requirement applies to previously finalized and adopted measures, as well as new measures proposed through the rulemaking process. Electronic submission is required for all HIS records. Although electronic submission of HIS records is required, hospices do not need to have an electronic medical record to complete or submit HIS data. In the FY 2014 Hospice Wage Index final rule (78 FR 48258), we finalized a provision requiring that providers use either the Hospice Abstraction Reporting Tool (HART) (which is free to download and use) or vendor-designed software to complete HIS records. HART provides an alternative option for hospice providers to collect and maintain facility, patient, and HIS Record information for subsequent submission to the QIES ASAP system. Once HIS records are complete, electronic HIS files must be submitted to CMS via the QIES ASAP system. Electronic data submission via the QIES ASAP system is required for all HIS submissions; there are no other data submission methods available. Hospices have 30 days from a patient admission or discharge to submit the appropriate HIS record for that patient through the QIES ASAP system. We will continue to make HIS completion and submission software available to hospices at no cost. We provided details on data collection and submission timing under the downloads section of the HIS Web page on the *CMS.gov* Web site at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>.

The QIES ASAP system provides reports upon successful submission and processing of the HIS records. The final validation report may serve as evidence of submission. This is the same data submission system used by nursing homes, inpatient rehabilitation facilities, home health agencies, and long-term care hospitals for the submission of Minimum Data Set Version 3.0 (MDS 3.0), Inpatient Rehabilitation Facility-patient assessment instrument (IRF-PAI), Outcome Assessment Information Set (OASIS), and Long-Term Care Hospital Continuity Assessment Record & Evaluation Data Set (LTCH CARE), respectively. We have provided hospices with information and details about use of the HIS through postings on the HQRP Web site, Open Door Forums, announcements in the CMS MLN Connects® Provider e-News (E-News), and provider training.

Hospices are evaluated for purposes of the quality reporting program based on whether or not they submit data, not on their substantive performance level for the required quality measures. In order for us to appropriately evaluate the quality reporting data received by hospice providers, it is essential HIS data be received in a timely manner.

The submission date is the date on which the completed record is submitted and accepted by the QIES ASAP system. In the FY 2016 Hospice Wage Index final rule (80 FR 47191), we finalized our policy that beginning with the FY 2018 payment determination, hospices must submit all HIS records within 30 days of the event date, which is the patient's admission date for HIS-Admission records or discharge date for HIS-Discharge records.

For HIS-Admission records, the submission date must be no later than the admission date plus 30 calendar days. The submission date can be equal to the admission date, or no greater than 30 days later. The QIES ASAP system will issue a warning on the Final Validation Report if the submission date is more than 30 days after the patient's admission date.

For HIS-Discharge records, the submission date must be no later than the discharge date plus 30 calendar days. The submission date can be equal to the discharge date, or no greater than 30 days later. The QIES ASAP system will issue a warning on the Final Validation Report if the submission date is more than 30 days after the patient's discharge date.

The QIES ASAP system validation edits are designed to monitor the timeliness of submission and ensure that providers' submitted records conform to the HIS data submission specifications. Providers are notified when timing criteria have not been met by warnings that appear on their Final Validation Reports. A standardized data collection approach that coincides with timely submission of data is essential to establish a robust quality reporting program and ensure the scientific reliability of the data received. In the FY 2016 Hospice Wage Index final rule (80 FR 47191), we also clarified the difference between the completion deadlines and the submission deadlines. Current sub-regulatory guidance produced by CMS (for example, HIS Manual, HIS trainings) states that the completion deadlines for HIS records are 14 days after the Event Date for HIS-Admission records and 7 days after the Event Date for HIS-Discharge records. Completion deadlines continue to reflect CMS guidance only; these guidelines are not statutorily specified

and are not designated through regulation. These guidelines are intended to offer clear direction to hospice agencies in regards to the timely completion of HIS-Admission and HIS-Discharge records. The completion deadlines define only the latest possible date on which a hospice should complete each HIS record. This guidance is meant to better align HIS completion processes with clinical workflow processes; however, hospices may develop alternative internal policies to complete HIS records. Although it is at the discretion of the hospice to develop internal policies for completing HIS records, we will continue to recommend that providers complete and attempt to submit HIS records early, prior to the previously finalized submission deadline of 30 days, beginning in FY 2018. Completing and attempting to submit records early allows providers ample time to address any technical issues encountered in the QIES ASAP submission process, such as correcting fatal error messages. Completing and attempting to submit records early will ensure that providers are able to comply with the 30 day submission deadline. HQRP guidance documents, including the CMS HQRP Web site, HIS Manual, HIS trainings, Frequently Asked Questions, and Fact Sheets, continue to offer the most up-to-date CMS guidance to assist providers in the successful completion and submission of HIS records. Availability of updated guidance will be communicated to providers through the CMS HQRP Web site, listserv messages via the Post-Acute Care QRP listserv, MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews and announcements on Open Door Forums and Special Open Door Forums.

d. New Data Collection and Submission Mechanisms Under Consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)

We have made great progress in implementing the objectives set forth in the quality reporting and data collection activities required by sections 3004 of the Affordable Care Act. To date, we have established the HQRP, which includes clinical quality measures from the HIS and patient experience of care measures from the CAHPS® Hospice Survey. We have also finalized payment reform measures, including changes to the RHC payment rate and the implementation of a Service Intensity Add-On (SIA) payment, effective January 1st, 2016.

As discussed in the FY 2017 final rule (81 FR 52177), to facilitate continued

progress towards the requirements set forth in section 3004 of the Affordable Care Act, we are in the early stages of the development of a new data collection mechanism for use by hospices. This new data collection mechanism would be a hospice patient assessment tool, which would serve two primary objectives concordant with the Affordable Care Act legislation: (1) To provide the quality data necessary for HQRP requirements and the current function of the HIS; and (2) provide additional clinical data that could inform future payment refinements. In the FY 2017 final rule (81 FR 52176 through 52179), we solicited input from the public on the development of a hospice patient assessment tool that would collect quality, clinical, and other data with the ability to be used to inform future payment refinement efforts. Overall, feedback from the public was supportive of the move towards a standardized patient assessment instrument, and commenters offered some guiding principles for CMS to keep in mind in the development of a patient assessment tool, given the unique nature of hospice care. For a detailed discussion of the public comments and responses, as well as CMS's guiding principles and motivation behind the development of a hospice patient assessment tool, we refer readers to the FY 2017 final rule (81 FR 52177 through 52179).

As noted in the FY 2017 final rule, we envision the hospice patient assessment tool itself as an expanded HIS. The hospice patient assessment tool would include current HIS items, as well as additional clinical items that could also be used for payment refinement purposes or to develop new quality measures. The hospice patient assessment tool would not replace existing requirements set forth in the Medicare Hospice CoPs (such as the initial and comprehensive assessment), but would be designed to complement data that are collected as part of high-quality clinical care. The new data collection effort would replace the current HIS, but would not replace other HQRP data collection efforts (that is, the CAHPS® Hospice Survey), nor would it replace regular submission of claims data. We envision that patient assessment data would be collected upon a patient's admission to and discharge from any Medicare-certified hospice provider; additional interim data collection efforts are also possible.

We are not proposing a hospice patient assessment tool at this time; we are still in the early stages of development of an assessment tool to determine the appropriate content and

feasibility of such a tool. As such, we have made progress over the past year in the development of a hospice patient assessment tool, preliminarily called the Hospice Evaluation & Assessment Reporting Tool (HEART). CMS's measure development contractor, RTI International, has begun preliminary HEART development activities, including: Conducting environmental scans and engaging clinical experts to determine which domains of care are important to capture in a hospice patient assessment; posting a national provider call and forming a Clinical Committee comprised of hospice organizations from across the U.S. to participate in the early development of an assessment; and collaborating within CMS to assess various stakeholder needs and encourage collaboration within CMS and across other HHS agencies. As we move forward with the development of the HEART patient assessment tool, we will continue to keep the public informed of our progress and solicit input as we establish and finalize domains of care to include in the assessment, and as we move towards specific item wording and development. Once we move past the preliminary phases of development and conceptualization, we will communicate a timeline for the HEART development, testing, and implementation in future rulemaking cycles.

As mentioned in the FY 2017 final rule, it is important for CMS to develop a hospice patient assessment tool that is scientifically rigorous and clinically appropriate for the hospice population, thus we believe that continued and transparent involvement of stakeholders is critical. We will continue to receive stakeholder input from MedPAC and ongoing input from the provider community, Medicare beneficiaries, and technical experts. Additionally, it is important for CMS to minimize data collection burden on providers; in the development of HEART. We will ensure that hospice patient assessment data items are not duplicative or overly burdensome to providers, patients, caregivers, or their families. We will also work with the public and other stakeholders to ensure that HEART takes into account the unique aspects of hospice care delivery including symptom burden and psychosocial needs, patient and family preferences, care of imminently dying patients, and the complexity of providing hospice care in multiple settings and at multiple intensity levels.

9. Previously Adopted APU Determination and Compliance Criteria for the HQRP

a. Background

The HQRP is currently designed as a "pay-for-reporting" system, meaning that it is the act of submitting data that determines compliance with HQRP requirements. Performance level is not a consideration when determining market basket updates/APU. Reporting compliance is determined by successfully fulfilling both the Hospice CAHPS® Survey requirements and the HIS data submission requirements.

b. Previously Finalized HIS Data Submission Timelines and Compliance Thresholds for FY 2018 Payment Determination and Subsequent Years

To accurately analyze quality reporting data received by hospice providers, it is imperative we receive ongoing and timely submission of all HIS-Admission and HIS-Discharge records. In the FY 2016 Hospice Wage Index final rule (80 FR 47192), we finalized the timeliness criteria for submission of HIS-Admission and HIS-Discharge records. The finalized timeliness criteria were in response to input from our stakeholders seeking additional specificity related to HQRP compliance affecting FY payment determinations and, due to the importance of ensuring the integrity of quality data submitted.

As stated in that rule, beginning with the FY 2018 payment determination and subsequent FY payment determinations, all HIS records would have to be submitted within 30 days of the event date, which is the patient's admission date or discharge date.

In conjunction with the timeliness criteria for submission of HIS-Admission and HIS-Discharge records, in the FY 2016 Hospice Wage Index final rule (80 FR 47192) we also finalized a policy to establish an incremental threshold for compliance over a 3-year period. To be compliant for the FY 2018 APU determination, hospices must submit no less than 70 percent of their total number of HIS-Admission and HIS-Discharge records by no later than 30 days from the event date. The timeliness threshold is set at 80 percent for the FY 2019 APU determination and at 90 percent for the FY 2020 APU determination and subsequent years. The threshold corresponds with the overall amount of HIS records received from each provider that fall within the established 30 day submission timeframes. Our ultimate goal is to require all hospices to achieve a compliance rate of 90 percent or more.

To summarize, in the FY 2016 Hospice Wage Index final rule (80 FR 47193), we finalized our policy to implement the timeliness threshold requirement beginning with all HIS-Admission and HIS-Discharge records that occur after January 1, 2016, in accordance with the following schedule:

- Beginning January 1, 2016 to December 31, 2016, hospices must submit at least 70 percent of all required HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2018.

- Beginning January 1, 2017 to December 31, 2017, hospices must submit at least 80 percent of all required HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2019.

- Beginning January 1, 2018 to December 31, 2018, hospices must submit at least 90 percent of all required HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2020.

In July of 2016, we released the Hospice Timeliness Compliance Threshold Report in the Certification and Survey Provider Enhanced Reports (CASPER) system. This report allows providers with a QIES ASAP User ID to check their preliminary compliance with the 70/80/90 timeliness compliance threshold described above. For more information on the Hospice Timeliness Compliance Threshold Report, we refer readers to the Timeliness Compliance Threshold Fact Sheet, available on the HIS portion of the CMS HQRP Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html> and Chapter 3 of the CASPER User's Manual, available on the QTSO Web site: <https://www.qtso.com/hospicetrain.html>.

In the FY 2016 Hospice Wage Index final rule (80 FR 47192 through 47193), we provided clarification regarding the methodology used in calculating the 70 percent/80 percent/90 percent compliance thresholds. In general, HIS records submitted for patient admissions and discharges occurring during the reporting period (January 1st to December 31st of the reporting year involved) will be included in the denominator for the compliance threshold calculation. The numerator of the compliance threshold calculation would include any records from the

denominator that were submitted within the 30 day submission deadline. In the FY 2016 Hospice Wage Index final rule (80 FR 47192), we also stated that we would make allowances in the calculation methodology for two circumstances. First, the calculation methodology will be adjusted following the applicable reporting period for records for which a hospice is granted an extension or exemption by CMS. Second, adjustments will be made for instances of modification/inactivation requests (Item A0050. Type of Record = 2 or 3). Additional helpful resources regarding the timeliness compliance threshold for HIS submissions can be found under the downloads section of the HIS Web page at *CMS.gov* at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>. Lastly, as further details of the data submission and compliance threshold are determined by CMS, we anticipate communicating these details through the CMS HQRP Web site, listserv messages via the Post-Acute Care QRP listserv, MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews and announcements on Open Door Forums and Special Open Door Forums.

c. CAHPS® Participation Requirements for FY 2018 APU Determination and Determinations for Subsequent Years

In the FY 2015 Hospice Wage Index final rule, we added the CAHPS® Hospice Survey to the Hospice Quality Reporting Program requirements for the FY 2017 payment determination and determinations for subsequent FY APU years (79 FR 50491).

In the FY 2017 Hospice Wage Index final rule, we finalized that to meet the HQRP requirements for the FY 2018, FY 2019 and FY 2020 APU payment determinations, hospices would collect survey data on a monthly basis for the months of January 1, 2016 through December 31, 2016 to qualify for the full FY 2018 APU; hospices would collect survey data on a monthly basis for the months of January 1, 2017 through December 31, 2017, to qualify for the full FY 2019 APU, and hospices would collect survey data on a monthly basis for the months of January 1, 2018 through December 31, 2018 for the full FY 2020 APU (81 FR 25529–25530). We are proposing in this FY 2018 proposed rule, that to meet the HQRP requirements for the FY 2021 APU payment determination, hospices would collect survey data on a monthly basis for the months of January 1, 2019 through December 31, 2019 to qualify

for the FY 2021 APU. We are additionally proposing in this FY 2018 proposed rule, that to meet the HQRP requirements for the FY 2022 APU payment determination, hospices would collect survey data on a monthly basis for the months of January 1, 2020 through December 31, 2020 to qualify for the FY 2022 APU.

10. HQRP Submission Exemption and Extension Requirements for the FY 2019 Payment Determination and Subsequent Years

a. Extraordinary Circumstances Exemption and Extension

In the FY 2015 Hospice Wage Index final rule (79 FR 50488), we finalized our proposal to allow hospices to request, and for CMS to grant, exemptions/extensions for the reporting of required HIS quality data when there are extraordinary circumstances beyond the control of the provider. Such extraordinary circumstances may include, but are not limited to, acts of nature or other systemic issues with our data systems. We further finalized that hospices must request such an exemption or extension within 30 days of the date that the extraordinary circumstances occurred.

In certain instances, however, it may be difficult for hospices to timely evaluate the impact of extraordinary circumstances within 30 calendar days. For other quality reporting programs such as the Hospital Inpatient Quality Reporting (81 FR 57182), Inpatient Rehabilitation Facility Quality Reporting Program (81 FR 52125) and the Long-term Care Hospital Quality Reporting Program (81 FR 25205), we have reevaluated our policy and subsequently finalized through rulemaking an extension of that period of time to 90 calendar days. We are therefore proposing to extend the deadline for submitting an exemption or extension request to 90 calendar days from the qualifying event which is preventing a hospice from submitting their quality data for the HQRP. We believe that extending the deadline to 90 calendar days would allow hospices more time to determine whether it is necessary and appropriate to submit an exemption or extension request and to provide a more comprehensive account of the qualifying event in their request form to CMS. For example, if a hospice has suffered damage due to a hurricane on January 1st, it would have until March 31st to submit a request form to CMS via email to the HQRP mailbox at *HospiceQRPreconsiderations@cms.hhs.gov*.

Further, while we finalized our policy in the past for exception/extension for the submission of the HIS data, we propose to extend this policy beyond the submission of the HIS date to submission of the CAHPS® Hospice Survey data, given that multiple data submission processes could be impacted by the same qualifying event.

Therefore, we are proposing for FY 2019 payment determination and subsequent payment determinations to extend the period of time a hospice may have to submit a request for an extension or exception for quality reporting purposes from 30 calendar days to 90 calendar days after the date that the extraordinary circumstances occurred, by submitting a request to CMS via email to the HQRP mailbox at *HospiceQRPreconsiderations@cms.hhs.gov*. Exemption or extension requests sent to us through any other channel will not be considered valid. The request for an exemption or extension must contain all of the finalized requirements as outlined on our Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Extensions-and-Exemption-Requests.html>.

If a hospice is granted an exemption or extension, timeframes for which an exemption or extension is granted will be applied to the new timeliness requirement so such hospices are not penalized. If a hospice is granted an exemption, we will not require that the hospice submit HIS and/or CAHPS® Hospice Survey data for a given period of time. By contrast, if we grant an extension to a hospice, the hospice will still remain responsible for submitting data collected during the timeframe in question, although we will specify a revised deadline by which the hospice must submit these quality data.

This process does not preclude us from granting extensions/exemptions to hospices that have not requested them when we determine that an extraordinary circumstance, such as an act of nature, affects an entire region or locale. We may grant an extension/exemption to a hospice if we determine that a systemic problem with our data collection systems directly affected the ability of the hospice to submit data. If we make the determination to grant an extension/exemption to hospices in a region or locale, we will communicate this decision through the various means, including the CMS HQRP Web site, listserv messages via the Post-Acute Care QRP listserv, MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews and announcements on Open Door Forums

and Special Open Door Forums. We are soliciting comments on these proposals.

b. Volume-Based Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements

We previously finalized a volume-based exemption for CAHPS® Hospice Survey Data Collection and Reporting requirements in the FY 2017 Final Rule (81 FR 52181). Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2017 through December 31, 2017 are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements for the FY 2020 payment determination (corresponds to the CY 2018 data collection period). To qualify, hospices must submit an exemption request form for the FY 2020 APU. The exemption request form is available on the official CAHPS® Hospice Survey Web site <http://www.hospiceCAHPSsurvey.org>. Hospices that intend to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2017 through December 31, 2017. The due date for submitting the exemption request form for the FY 2020 APU is December 31, 2018. Small hospices that meet the exemption for size criteria for FY 2020 must complete an exemption form for FY 2020. Exemptions for size are active for 1 year only. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization needs to request the exemption annually for every applicable FY APU period.

Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2018 through December 31, 2018 are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements for the FY 2021 payment determination. Hospices that intend to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2018 through December 31, 2018. The due date for submitting the exemption request form for the FY 2021 APU is December 31, 2019. Small hospices that meet the exemption for size criteria for FY 2021 must complete an exemption form for FY 2021.

Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2019 through December 31, 2019 are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements for the FY 2022 payment determination. Hospices that intend to claim the size exemption are required to

submit to CMS their total unique patient count for the period of January 1, 2019 through December 31, 2019. The due date for submitting the exemption request form for the FY 2022 APU is December 31, 2020. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization should request the exemption annually for every applicable FY APU period.

c. Newness Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements

CMS previously finalized a one-time newness exemption for hospices that meet the criteria (81 FR 52181). Accordingly, hospices that are notified about their Medicare CCN after January 1, 2018 are exempted from the FY 2020 APU CAHPS® Hospice Survey requirements due to newness. No action is required on the part of the hospice to receive this exemption. The newness exemption is a one-time exemption from the survey. Likewise, hospices notified about their Medicare CCN after January 1, 2019 are exempted from the FY 2021 APU CAHPS® Hospice Survey and hospices notified about their Medicare CCN after January 1, 2020 are exempted from the FY 2022 APU CAHPS® Hospice Survey requirements.

11. CAHPS® Hospice Survey Participation Requirements for the FY 2020 APU and Subsequent Years

The CAHPS® Hospice Survey of CMS' Hospice Quality Reporting Program is used to collect data on the experiences of hospice patients and the primary caregivers listed in their hospice records. Readers who want more information are referred to our extensive discussion of the Hospice Experience of Care prior to our proposal for the public reporting of measures should refer to 79 FR 50452 and 78 FR 48261.

a. Background and Description of the CAHPS® Hospice Survey

The CAHPS® Hospice Survey is the first standardized national survey available to collect information on patient's and informal caregiver's experience of hospice care. Patient-centered experience measures are a key component of the CMS Quality Strategy, emphasizing patient-centered care by rating experience as a means to empower patients and their caregivers and improving the quality of their care.²⁸ In addition, the survey

²⁸ CMS National Quality Strategy 2016. Available at: <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/downloads/cms-quality-strategy.pdf>.

introduces standard survey administration protocols that allow for fair comparisons across hospices.

Details regarding CAHPS® Hospice Survey national implementation, survey administration, participation requirements, exemptions from the survey's requirements, hospice patient and caregiver eligibility criteria, fielding schedules, sampling requirements, survey instruments, and the languages that are available for the survey, are all available on the official CAHPS® Hospice Survey Web site, www.HospiceCAHPSsurvey.org and in the *CAHPS® Hospice Survey Quality Assurance Guidelines (QAG)*, which is posted on the Web site.

b. Overview of Proposed Measures

The CAHPS Hospice Survey was developed in line with the U.S. Department of Health and Human Services' Transparency Initiative to measure patient experience. Unlike the Hospital CAHPS® Survey deployed in 2006 (71 FR 48037 through 48039) and other subsequent CAHPS® surveys, the CAHPS® Hospice Survey is administered after the patient is deceased and queries the decedent's primary caregiver regarding the patient and family experience of care. National implementation of the CAHPS® Hospice Survey commenced January 1, 2015 as stated in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452).

The survey consists of 47 questions and is available (using the mailed version) in English, Spanish, Chinese, Russian, Portuguese, Vietnamese, Polish, and Korean. It covers topics such as access to care, communications, experience at hospice facilities, and interactions with hospice staff. The survey also contains two global rating questions and asks for self-reported demographic information (race/ethnicity, educational attainment level, languages spoken at home, among others).

The CAHPS® Hospice Survey measures received NQF endorsement on October 26th, 2016 (NQF number 2651). Measures derived from the CAHPS® Hospice Survey include six multi-item (composite) measures and two global ratings measures under NQF 2651. We are proposing to adopt these eight survey-based measures for the CY 2018 data collection period and for subsequent years. We believe these survey-based measures will be useful in assessing aspects of hospice care where the family/primary caregiver is the most useful or only source of information, and to allow meaningful and objective comparisons between hospice

providers. The six CAHPS® Hospice Survey composite survey-based measures are:

- Hospice Team Communication;
- Getting Timely Care;
- Treating Family Member with

Respect;

• Getting Emotional and Religious Support;

- Getting Help for Symptoms; and
- Getting Hospice Care Training.

Each of the six composite survey-based measures consists of two or more questions. The two global survey-based measures are:

- Rating of Hospice; and
- Willingness to Recommend

Hospice.

The two global survey-based measures are comprised of a single question each and ask the primary caregiver of the decedent to rate the care provided by the hospice facility and his or her willingness to recommend the hospice to family and friends. More information about these measures can be found on the official CAHPS® Hospice Survey Web site, www.HospiceCAHPSsurvey.org and in the CAHPS® Hospice Survey Quality Assurance Guidelines (QAG), which is posted on the Web site.

The eight survey-based measures we are proposing were included on the CY 2016 MUC²⁹ list, and reviewed by the MAP.³⁰

- CAHPS® Hospice Survey: Rating of Hospice (MUC ID: MUC16–31)
- CAHPS® Hospice Survey: Hospice Team Communications (MUC16–32)
- CAHPS® Hospice Survey: Willingness to Recommend (MUC16–33)
- CAHPS® Hospice Survey: Getting Hospice Care Training (MUC16–35)
- CAHPS® Hospice Survey: Getting Timely Care (MUC16–36)
- CAHPS® Hospice Survey: Getting Emotional and Religious Support (MUC16–37)
- CAHPS® Hospice Survey: Getting Help for Symptoms (MUC16–39)
- CAHPS® Hospice Survey: Treating Family Member with Respect (MUC16–40)

The MAP supported rulemaking for all eight “patient-reported” measures derived from the CAHPS® Hospice Survey. The MAP noted that the

CAHPS® Hospice Survey measures may offer an indication of global quality of care by including the perspective of both patients and their caregivers.

c. Data Sources

As discussed in the CAHPS® Hospice Survey Quality Assurance Guidelines V3.0 (QAG V3.0) (<http://www.hospicecahpsurvey.org/en/quality-assurance-guidelines/>), the survey has three administration methods: Mail-only, telephone only, and mixed mode (mail with telephone follow-up of non-respondents). We previously finalized the participation requirements for the FY 2018 and FY 2019 Annual Payment Updates (80 FR 47194). To summarize, to meet the CAHPS® Hospice Survey requirements for the HQR, we are proposing that hospice facilities must contract with a CMS-approved vendor to collect survey data for eligible patients on a monthly basis and report that data to CMS on the hospice’s behalf by the quarterly deadlines established for each data collection period. The list of approved vendors is available at: <http://www.hospicecahpsurvey.org/en/approved-vendor-list>.

Hospices are required to provide lists of the patients who died under their care, along with the associated primary caregiver information, to their respective survey vendors to form the samples for the CAHPS® Hospice Survey. We emphasize the importance of hospices providing complete and accurate information to their respective survey vendors in a timely manner. Hospices must contract with an approved CAHPS® Hospice Survey vendor to conduct the survey on their behalf. Hospices are responsible for making sure their respective survey vendors meet all data submission deadlines. Vendor failures to submit data on time are the responsibility of the hospices.

i. Requirements for the FY 2020 Annual Payment Update

To meet participation requirements for the FY 2020 annual payment update (APU), Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2018 through December 2018 (all 12 months) in order to receive their full payment for the FY 2020 APU. All data submission deadlines for the FY 2020 APU are in Table 17. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 17 for all APU periods listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the

control of the provider as discussed above.

TABLE 17—CAHPS® HOSPICE SURVEY DATA SUBMISSION DATES FOR THE APU IN FY 2020, FY 2021, AND FY 2022

Sample months (that is, month of death) ¹	Quarterly data submission deadlines ²
FY 2020 APU	
January–March 2018 (Q1).	August 8, 2018.
April–June 2018 (Q2)	November 14, 2018.
July–September 2018 (Q3).	February 13, 2019.
October–December 2018 (Q4).	May 8, 2019.
FY 2021 APU	
January–March 2019 (Q1).	August 14, 2019.
April–June 2019 (Q2)	November 13, 2019.
July–September 2019 (Q3).	February 12, 2020.
October–December 2019 (Q4).	May 13, 2020.
FY 2022 APU	
January–March 2020 (Q1).	August 12, 2020.
April–June 2020 (Q2)	November 12, 2020. ³
July–September 2020 (Q3).	February 10, 2021.
October–December 2020 (Q4).	May 12, 2021.

¹ Data collection for each sample month initiates 2 months following the month of patient death (for example, in April for deaths occurring in January).

² Data submission deadlines are the second Wednesday of the submission months, which are the months August, November, February, and May.

³ Second Wednesday is Veterans Day Holiday.

ii. Requirements for the FY 2021 Annual Payment Update

To meet participation requirements for the FY 2021 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2019 through December 2019 (all 12 months) in order to receive their full payment for the FY 2021 APU. All data submission deadlines for the FY 2021 APU are in Table 17. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 17 for all APU periods listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the control of the provider as discussed above.

²⁹ CMS, *List of Measures Under Consideration for December 1, 2016*. Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/Measures-under-Consideration-List-for-2016.pdf>.

³⁰ The National Quality Forum. *MAP 2016–2017 Preliminary Recommendations*. National Quality Forum, 2016 Recommendations for Measures Under Consideration, Jan. 2017. Available at: <http://www.qualityforum.org/map/>.

iii. Requirements for the FY 2022 Annual Payment Update

To meet participation requirements for the FY 2022 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2020 through December 2020 (all 12 months) in order to receive their full payment for the FY 2022 APU. All data submission deadlines for the FY 2022 APU are in Table 17. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 17 for all APU periods listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the control of the provider as discussed above.

d. Measure Calculations

As noted above, we are proposing to adopt six composite CAHPS® Hospice Survey-based measures and two global survey-based measures. As with other measures adopted for HQR, a hospice's performance for a given payment determination year will be based upon the successful submission of data required in accordance with the administrative, form, manner and timing requirements established for the program. Therefore, hospices' scores on the CAHPS® Hospice Survey-based measures will not affect whether they are subject to the 2.0 percentage point

payment reduction for hospices that fail to report data required to be submitted.

We propose that CAHPS Hospice Survey scores for a given hospice be displayed as "top-box" scores, with the national average top-box score for participating hospices provided for comparison. Top-box scores reflect the proportion of caregiver respondents that endorse the most positive response(s) to a given measure, such as the proportion that rate the hospice a 9 or 10 out of 10 on a 0 to 10 scale, or the proportion that report that they "always" received timely care. The top-box numerator for each question within a measure is the number of respondents that endorse the most positive response(s) to the question. The denominator includes all respondents eligible to respond to the question, with one exception. The exception is the Getting Hospice Care Training measure; for this measure, the measure score is calculated only among those respondents who indicated that their family member received hospice care at home or in an assisted living facility.

For additional information on the specifications of these measures, including details regarding top-box scoring methodology and mode and case-mix adjustment, please refer to the CAHPS® Hospice Survey Web page at <http://www.hospicecahpsurvey.org/en/>.

i. Composite Survey-Based Measures

Unadjusted hospice scores on each composite CAHPS® Hospice Survey-

based measure would be calculated by determining the proportion of "top-box" responses for each question within the composite and averaging these proportions over all the questions in the composite measure. For example, to assess hospice performance on the composite measure CAHPS® Hospice Survey—Hospice Team

Communication, we would calculate the proportion of top-box responses for each of the measure's six questions, add those proportions together, and divide by the number of questions in the composite measure (in this case, six).

As a specific example, we take a theoretical hospice facility that had 50 surveys completed and received the proportions of "top-box" responses through sample calculations:

- 25 "top-box" responses out of 50 total responses on Question One
- 40 "top-box" responses out of 50 total responses on Question Two
- 50 "top-box" responses out of 50 total responses on Question Three
- 35 "top-box" responses out of 50 total responses on Question Four
- 45 "top-box" responses out of 50 total responses on Question Five
- 40 "top-box" responses out of 50 total responses on Question Six

Based on the above responses, we would calculate that hospice's unadjusted measure score for public reporting as follows:

$$\text{Publicly Reported Score} = \frac{(0.5 + 0.8 + 1 + 0.7 + 0.9 + 0.8)}{6}$$

This calculation would give this example hospice an unadjusted score of 0.78 or 78 percent for the Hospice Team Communication measure for purposes of public reporting. We note that an adjusted hospice score would be calculated by adjusting the score for each question for differences in the characteristics of decedents and caregivers across hospices and for mode as described in section 11.e, and then averaging across questions within the measure as described here. Further detailed information regarding scoring and risk adjustment can be found at the CAHPS® Hospice Survey Web site (<http://www.hospicecahpsurvey.org/en/technical-specifications/>).

ii. Global Survey-Based Measures

We are proposing to adopt two global CAHPS® Hospice Survey measures. CAHPS® Hospice Survey—Rating of Hospice asks the primary caregiver of

the decedent to rate the care provided by the hospice on a scale of 0 to 10, and CAHPS® Hospice Survey—Willingness to Recommend asks about the caregiver's willingness to recommend the hospice to family and friends on a scale of "Definitely No" to "Definitely Yes". Unadjusted hospice performance on each of the two global CAHPS® Hospice Survey-based measures would be calculated by the proportion of respondents providing high-value responses (that is, a 9 to 10 rating or "Definitely Yes") to the survey questions over the total number of respondents. For example, if a hospice received 45 9- and 10-point ratings out of 50 responses, this hospital would receive a 0.9 or 90 percent unadjusted score, which would then be adjusted for differences in the characteristics of decedents and caregivers across

hospices and modes, as described in section 12.E.

iii. Cohort

The CAHPS® Hospice Survey is administered to all eligible patients/caregivers—or a random sample thereof—who meet the eligibility criteria. Eligible patients, regardless of insurance or payment, can participate.

For purposes of each survey-based measure captured in the CAHPS® Hospice Survey, an "eligible patient" is a decedent 18 years or older:

- With death at least 48 hours following last admission to hospice care
 - for whom there is a caregiver of record
 - whose caregiver is someone other than a non-familial legal guardian
 - for whom the caregiver has a U.S. or U.S. Territory home address
- Patients who are still alive or whose admission to the hospice resulted in a

live discharge, are not eligible to participate in the survey. In addition, decedents/caregivers who initiate or voluntarily request that the hospice not reveal the patient's identity; and/or not survey the patient/caregiver ("no publicity patients/caregivers") are excluded from the sample.

e. Risk Adjustment

The CAHPS® Hospice Survey measures assess activities that are fully under the control of hospice care professionals and/or hospice organizations. In order to ensure fair comparisons in public reporting, we believe it is necessary and appropriate to adjust for factors that are not directly related to hospice performance, such as patient mix, for these CAHPS® Hospice Survey measures. The survey based measures are adjusted for decedent and caregiver characteristics (including the lag time between patient death and survey response; decedent's age, payer for hospice care, decedent's primary diagnosis, decedent's length of final episode of hospice care, caregiver's education, decedent's relationship to caregiver, caregiver's preferred language and language in which the survey was completed, and caregiver's age) known to be associated with systematic difference in survey responses.

i. Patient Mix Adjustment

Previous research, on both CAHPS® surveys and other types of surveys, has identified respondent characteristics that are not under the control of the entities being assessed but tend to be related to survey responses. Hence, variations in the proportion of respondents with such characteristics will be associated with variations in survey responses that are unrelated to the actual quality of hospice care. To ensure that comparisons between hospices reflect differences in performance rather than differences in patient and/or caregiver characteristics, publicly reported hospice scores will be adjusted for variations of such characteristics across hospices. This adjustment is performed using a linear regression model applied to all data within a quarter, with indicator variables for each hospice and each characteristic as an independent variable in the model.

ii. Mode Adjustment

We conducted an experiment to determine whether survey mode adjustments were needed to fairly compare CAHPS® Hospice Survey scores. The experiment found that mode adjustments are needed. Publicly reported CAHPS® Hospice Survey

scores will be adjusted for the mode of survey administration, which affects scores but is not related to quality of hospice care. (Authorized survey modes are: Mail-only, telephone-only, and mail with telephone follow up, also called mixed mode.) Mode adjustment is performed prior to patient-mix adjustment; a mode adjustment value is added/subtracted (depending on the mode) to each response to the survey by mail-only mode or mixed mode. Responses obtained using telephone-only mode are not adjusted since this is the reference mode.

As a result of the risk adjustment methodologies proposed here, the final percentages may vary from the unadjusted percentage as calculated in the examples provided above.

f. For Further Information About the CAHPS® Hospice Survey

We encourage hospices and other entities to learn more about the survey on www.hospicecahpsurvey.org. For direct questions, please contact the CAHPS® Hospice Survey Team at hospicecahpsurvey@HCQIS.org or telephone 1-844-472-4621.

12. HQRP Reconsideration and Appeals Procedures for the FY 2018 Payment Determination and Subsequent Years

In the FY 2015 Hospice Wage Index final rule (79 FR 50496), we notified hospice providers on how to seek reconsideration if they received a noncompliance decision for the FY 2016 payment determination and subsequent years. A hospice may request reconsideration of a decision by CMS that the hospice has not met the requirements of the HQRP for a particular period.

We clarified that any hospice that wishes to submit a reconsideration request must do so by submitting an email to CMS containing all of the requirements listed on the HQRP Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html>. Electronic email sent to HospiceQRPreconsiderations@cms.hhs.gov is the only form of submission that will be accepted. Any reconsideration requests received through any other channel including the United States Postal Service (USPS) or phone will not be considered as a valid reconsideration request. In the FY 2017 final rule we further clarified that providers should submit reconsideration requests of decision by CMS that the hospice has not met the CAHPS® Hospice Survey requirements using the same process (81 FR 52181)

(Details about the reports and emails received after data submission are in the CAHPS® *Hospice Quality Assurance Guidelines*, which is available on the official CAHPS® Hospice Survey Web site, www.hospicecahpsurvey.org). We codified this process at § 418.312(h). In addition, we codified at § 418.306(b)(2) that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements for that FY and solicited comments on all of the proposals and the associated regulations text at § 418.312 and in § 418.306 in section VI. Official instructions regarding the payment reduction reconsideration process can be located under the Regulations and Guidance, Transmittals, 2015 Transmittals Web site at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017-Transmittals.html>.

In the past, only hospices found to be non-compliant with the reporting requirements set forth for a given payment determination received a notification from CMS of this finding along with instructions for requesting reconsideration in the form of a USPS letter. In the FY 2016 Hospice Wage Index final rule (80 FR 47198), we stated that we would use the QIES CASPER reporting system as an additional mechanism to communicate to hospices regarding their compliance with the reporting requirements for the given reporting cycle. We have implemented this additional communication mechanism via the CASPER Hospice Timeliness Compliance Threshold Report previously discussed in the FY 2017 Hospice Wage Index rule at 81 FR 25527 and 25528. We will continue to send notification of noncompliance via delivery of a letter via the USPS. We previously finalized our proposal (80 FR 47198) to publish a list of hospices who successfully meet the reporting requirements for the applicable payment determination on the CMS HQRP Web site. The list of providers found to be compliant with the FY 2017 APU requirements can be found on the CMS HQRP Web site here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.html>.

13. Confidential Feedback Reports

As part of our effort to promote use of standardized quality data to improve quality of care, in December 2016, we made available two new provider feedback reports: The Hospice-Level

Quality Measure Report and the Patient Stay-Level Quality Measure Report. These confidential feedback reports are available to each hospice using the CASPER system, and are part of the class of CASPER reports known as Quality Measure (QM) Reports. These reports are separate from public reporting and are for provider viewing only, for the purposes of internal provider quality improvement. These reports are on-demand and thus enable hospice providers to view and compare their performance to the national average for a reporting period of their choice.

Providers are able to view their data and information at both the hospice and patient stay levels for its HIS based quality measures. The CASPER hospice-level QM Reports contain information such as the numerator, denominator, hospice-level QM score, and national average. The CASPER patient stay-level QM Reports show whether each patient stay is counted toward each quality measure. The HIS based QMs reported in both reports include:

- NQF #1641 Treatment Preferences
- NQF #1647 Beliefs/Values
- NQF #1634 Pain Screening
- NQF #1637 Pain Assessment
- NQF #1639 Dyspnea Screening
- NQF #1638 Dyspnea Treatment
- NQF #1617 Bowel Regimen

For more information on the CASPER QM Reports, we refer readers to the CASPER QM Factsheet on the HQRP Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.html>. This fact sheet contains detailed information about each CASPER QM report currently available, the data included in the reports, and how providers can use the reports as part of their Quality Assessment and Performance Improvement (QAPI) efforts. For technical information on the reports and how to access the CASPER QM Reports, we refer readers to: <https://www.qtsa.com/hospicetrain.html>.

As new HIS measures are implemented in the HQRP, we will continue to expand the functionality of the QM reports to allow providers to view data on additional HIS measures. We will announce refinements and additions to the QM reports through sub-regulatory communication channels and in future rulemaking cycles.

We also propose to provide hospices with preview reports of their data prior to the quarterly publication of CAHPS® Hospice Survey data on the Compare site. The reports will be provided

through the CASPER reporting system. Each hospice will receive only its own, individual reports.

14. Public Display of Quality Measures and Other Hospice Data for the HQRP

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any quality data submitted by hospices available to the public. These procedures shall ensure that a hospice has the opportunity to review the data that is to be made public for the hospice prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on a publicly available CMS Web site.

In the FY 2017 rule, we discussed our analysis of HIS data to inform which measures were eligible for public reporting and reportability analysis to determine data selection period and minimum denominator size for measures to be publicly reported. Based on analysis results, we determined that all 7 HIS quality measures adopted for the FY 2016 and beyond (NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1641, NQF #1647, NQF #1617), calculated based on a rolling 12 month data selection period, to be eligible for public reporting with a minimum denominator size of 20 patient stays. For additional details on these analyses, we refer readers to the FY 2017 final rule (81 FR 52183 through 52184).

In the FY 2017 final rule we also clarified policies for reportability analyses for new measures. As stated in the FY 2017 final rule, new measures will undergo reportability analysis to determine (1) appropriateness for public reporting and (2) appropriate data selection period. In accordance with discussion in the prior year's rule, we will use the same analytic approach used in previous reportability analyses to determine data selection period and minimum denominator size for the Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission. We will begin reportability analyses for the Hospice Visits When Death is Imminent Measure Pair once data for the measure are available. Results of reportability analyses conducted for these new measures will be communicated through future rulemaking.

To meet the Affordable Care Act's requirement for making quality measure data public, we are developing a CMS Hospice Compare Web site, which will allow consumers, providers and stakeholders to search for all Medicare-certified hospice providers and view their information and quality measure scores. We anticipate that public

reporting of HQRP data on the CMS Compare Web site will begin sometime in the summer of CY 2017. To help providers prepare for public reporting, we will offer opportunities for stakeholder engagement and education prior to the rollout of a CMS Hospice Compare site. We will offer outreach opportunities for providers through CMS HQRP Public reporting Web page: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Public-Reporting.html>, listserv messages via the Post-Acute Care QRP listserv, MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews and announcements on Open Door Forums and Special Open Door Forums. Finally, we will offer educational support and outreach to all hospice providers on the systems and processes for reviewing their data prior to public reporting; availability of educational support and outreach opportunities will be communicated through the listed channels above.

We will provide hospices an opportunity to preview their quality measure data prior to publicly reporting information. These quality measure data reports or "preview reports" will be made available in the CASPER system prior to public reporting and will offer providers the opportunity to preview their quality measure data prior to public reporting on the CMS Hospice Compare Web site. We will provide hospices 30 days to review the preview report beginning from the date on which they can access the report. Hospices will have an opportunity to request review of their data by CMS during the 30-day preview period if they believe that errors in data submitted to CMS may have resulted in incorrect measure scores and can submit proof along with a plan describing how the errors will be corrected. We will review these requests and if we confirm that the errors have affected the measures and agree to correct the measure, we will suppress the measure on the Hospice Compare Web site for one time only and display the corrected measure during the subsequent quarterly refresh of the Compare Web site. When the preview reports are ready for providers to access, anticipated summer of CY 2017 prior to the release of Hospice Compare, we will post the policies and procedures for providers to submit requests for reviewing of their data by CMS on the CMS HQRP Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment->

Instruments/Hospice-Quality-Reporting/Hospice-Quality-Public-Reporting.html.

CMS encourages hospices to use CASPER QM Reports (see section III.D.14 of this proposed rule) to review their HIS quality measures after they submit the HIS data to CMS. If hospices determine that erroneous data have been submitted, they should submit either of these two types of HIS records: Modify existing record or inactivate existing record to correct their data. HIS data corrected before the data are frozen for the creation of the preview reports will be reflected in the preview reports.

We propose to begin public reporting of CAHPS® Hospice Survey measures in 2018. Specifically, we are proposing to publicly report data in winter CY 2018 on all eight CAHPS® Hospice Survey measures. Scores would be displayed based on eight rolling quarters of data and would initially use CAHPS® Hospice Survey data collected from caregivers of patients who died while receiving hospice care between April 1, 2015 and March 31, 2017. We are proposing that the display of these scores be updated quarterly, and that scores be displayed only for those hospices for which there are 30 or more completed questionnaires during the reporting period. Scores will not be displayed for hospices with fewer than 30 completed questionnaires during the reporting period.

Like other CMS Compare Web sites, the Hospice Compare Web site will, in time, feature a quality rating system that gives each hospice a rating of between 1 and 5 stars. Hospices will have prepublication access to their own agency's quality data, which enables each agency to know how it is performing before public posting of data on the Hospice Compare Web site. Public comments regarding how the rating system would determine a hospice's star rating and the methods used for calculations, as well as a proposed timeline for implementation will be announced via the CMS HQRP Web page, listserv messages via the Post-Acute Care QRP listserv, MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews and announcements on Open Door Forums and Special Open Door Forums. We will announce the timeline for development and implementation of the star rating system in future rulemaking.

Lastly, as part of our ongoing efforts to make healthcare more transparent, affordable, and accountable for all hospice stakeholders, we have posted a hospice directory and quality data on a public data set located at <https://data.medicare.gov>. This data will serve as a helpful resource regarding

information on Medicare-certified hospice agencies throughout the nation. In an effort to move toward public reporting of hospice data, we have initially posted demographic data of hospice agencies that have been registered with Medicare. This list includes high-level demographic data for each agency, including provider name, address, phone numbers, ownership type, CCN, profit status, and date of original CMS certification. The posting of this hospice data directory occurred on June 14, 2016 and will be refreshed quarterly. Information can be located at <https://data.medicare.gov/data/hospice-directory>. Additionally, we have posted two hospice data files containing national level aggregate quality data regarding seven HIS quality measures and CAHPS® Hospice Survey measures in December 2016. These data file are a one-time release with a goal to make quality data available prior to the release of the Hospice Compare in summer of CY 2017. Additional details regarding hospice datasets will be announced via the CMS HQRP Web page, listserv messages via the Post-Acute Care QRP listserv, MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews and announcements on Open Door Forums and Special Open Door Forums. In addition, we have provided the list of CASPER/ASPEN contacts, Regional Office and State coordinators in the event that a Medicare-certified agency is either not listed in the database or the characteristics/administrative data (name, address, phone number, services, or type of ownership) are incorrect or have changed. To continue to meet Medicare enrollment requirements, all Medicare providers are required to report changes to their information in their enrollment application as outlined in the Provider-Supplier Enrollment Fact Sheet Series located at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_InstProv_FactSheet_ICN903783.pdf. Once the Hospice Compare Web site is released in the summer of CY 2017, <https://data.medicare.gov> will post the official datasets used on the Medicare.gov Compare Web sites provided by CM.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and

approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Unless noted otherwise, all salary information is from the Bureau of Labor Statistics (BLS) Web site at <http://www.bls.gov/oes> and includes a fringe benefits package worth 100 percent of the base salary. The mean hourly wage rates are based on May, 2015 BLS data for each discipline.

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. This data must be submitted in a form and manner, and at a time specified by the Secretary.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. Hospice Item Set

In the FY 2014 Hospice Wage Index final rule (78 FR 48257), and in compliance with section 1814(i)(5)(C) of the Act, we finalized the specific collection of data items that support the following 7 NQF endorsed measures for hospice:

- NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen,
- NQF #1634 Pain Screening,
- NQF #1637 Pain Assessment,
- NQF #1638 Dyspnea Treatment,
- NQF #1639 Dyspnea Screening,
- NQF #1641 Treatment Preferences,
- NQF #1647 Beliefs/Values Addressed (if desired by the patient).

We finalized the following two additional measures in the FY 2017 Hospice Wage Index final rule affecting FY 2019 payment determinations (81 FR 52163 through 52173):

- Hospice Visits when Death is Imminent
- Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

Data for the aforementioned 9 measures is collected via the HIS as

discussed in the FY 2017 Hospice Wage Index final rule (81 FR 52189) and covered under OMB control number 0938–1153. The HIS V2.00.0 was approved by the Office of Management and Budget on April 17, 2017 under control number 0938–1153. We are not proposing any new updates or additional collections of information in this proposed rule in regards to the Hospice Item Set or its constituent quality measures.

B. Summary of CAHPS® Hospice Survey Information Collection Requirements (OMB Control Number 0938–1257)

National Implementation of the Hospice Experience of Care Survey (CAHPs Hospice Survey) data measures are covered under OMB control number 0938–1257 and is summarized here for convenience. We have implemented patient experience surveys in a number of settings including Medicare, Medicare Advantage, and Part D Prescription Drug Plans, hospitals, and home health agencies. Other CAHPS® surveys exist for hemodialysis facilities, nursing homes, and physician practices. The hospice survey differs from most other CMS patient experience surveys because its target population is bereaved family members or close friends of patients who died in hospice care. Family members and friends are the best

source of information regarding the entire trajectory of hospice care. In addition, many hospice patients are very ill and unable to answer survey questions.

Surveys are administered by CMS-approved survey vendors hired by hospice providers to conduct the survey on their behalf. The survey vendor may collect data in one of three modes: Mail-only, telephone-only, or mixed mode (mail with telephone follow-up). The sample consists of bereaved family members or close friends of patients who died while receiving hospice care (1) at home, (2) in a nursing home, or (3) an inpatient setting (that is, freestanding inpatient unit or acute care hospital). The questionnaire is composed of 47 items.

The estimated annualized burden hours and costs to respondents for the national implementation of the CAHPS® Hospice Survey are shown in Tables 18 and 19. Based on participation in national implementation in the CAHPS® Hospice Survey from Quarter 2 2015 through Quarter 1 2016, we assume that 3,414 hospices will administer the survey to an average of 278.7 cases. Thus, we estimate that the CAHPS® Hospice Survey will be administered to a maximum of 951,482 individuals each year for the duration of the collection period covered by this application for

the purposes of national implementation. As not all sampled cases will complete the survey, this estimate reflects the maximum burden possible. The estimated number of responses is based on actual hospice participation in national implementation of the CAHPS® Hospice Survey.

Table 18 shows the estimated annualized burden for the respondents' time to participate in the national implementation data collection. The survey contains 47 items and is estimated to require an average administration time of 10.4 minutes in English (at a pace of 4.5 items per minute) and 12.5 minutes in Spanish (assuming 20 percent more words in the Spanish translation), for an average response time of 10.47 minutes or 0.174 hours (assuming that 1 percent of survey respondents complete the survey in Spanish). These burden and pace estimates are based on CMS' experience with the CAHPS® Hospice Survey and surveys of similar length that were fielded with Medicare beneficiaries. As indicated below, the annual total burden hours for survey participants are estimated to be 165,959.57 for the continued national implementation of the survey.

TABLE 18—ESTIMATED ANNUALIZED BURDEN HOURS FOR RESPONDENTS: NATIONAL IMPLEMENTATION OF THE CAHPS® HOSPICE SURVEY

Survey version	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
CAHPS® Hospice Survey	951,482	1	0.174	165,959.57
Total	951,482	1	0.174	165,959.57

Table 19 shows the cost burden to respondents associated with their time to complete a survey as part of national implementation. The annual total cost

burden is estimated to be \$7,710,481.60. This estimate is higher than the \$3,034,789.70 estimated in the prior OMB filing, due to the increased

number of hospices participating (and correspondingly, the increased number of respondents), as well as an increase in the average hourly rate.

TABLE 19—ESTIMATED ANNUALIZED COST BURDEN FOR RESPONDENTS: NATIONAL IMPLEMENTATION

Form name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
CAHPS® Hospice Survey	951,482	165,959.57	*\$46.46	\$7,710,481.60
Total	951,482	165,959.57	*\$46.46	\$7,710,481.60

* Source: Data from the U.S. Bureau of Labor Statistics' May 2015 National Occupational Employment and Wage Estimates for all salary estimates (<http://www.bls.gov/oes>). This figure includes a 100% fringe benefit on an average wage of \$23.23. Retrieved April 10, 2017.

If you comment on these information collection, that is, reporting, recordkeeping or third-party disclosure requirements, please submit your

comments electronically as specified in the **ADDRESSES** section of this proposed rule.

Comments must be received by 5 p.m. June 26, 2017.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Request for Information on CMS Flexibilities and Efficiencies

CMS is committed to transforming the health care delivery system—and the Medicare program—by putting an additional focus on patient-centered care and working with providers, physicians, and patients to improve outcomes. We seek to reduce burdens for hospitals, physicians, and patients, improve the quality of care, decrease costs, and ensure that patients and their providers and physicians are making the best health care choices possible. These are the reasons we are including this Request for Information in this proposed rule.

As we work to maintain flexibility and efficiency throughout the Medicare program, we would like to start a national conversation about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families. We aim to increase quality of care, lower costs improve program integrity, and make the health care system more effective, simple and accessible.

We would like to take this opportunity to invite the public to submit their ideas for regulatory, subregulatory, policy, practice, and procedural changes to better accomplish these goals. Ideas could include payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences. Responses to this Request for Information could also include recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers, and suppliers. Where practicable, data and

specific examples would be helpful. If the proposals involve novel legal questions, analysis regarding CMS' authority is welcome for CMS' consideration. We are particularly interested in ideas for incentivizing organizations and the full range of relevant professionals and paraprofessionals to provide screening, assessment and evidence-based treatment for individuals with opioid use disorder and other substance use disorders, including reimbursement methodologies, care coordination, systems and services integration, use of paraprofessionals including community paramedics and other strategies. We are requesting commenters to provide clear and concise proposals that include data and specific examples that could be implemented within the law.

We note that this is a Request for Information only. Respondents are encouraged to provide complete but concise responses. This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This Request for Information does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will be solely at the interested party's expense. We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this Request for Information. CMS will not respond to comment submissions in response to this Request for Information in the FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule. Rather, CMS will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. CMS may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the

responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a nonattribution basis. Respondents should not include any information that might be considered proprietary or confidential. This Request for Information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. CMS may publicly post the public comments received, or a summary of those public comments.

VII. Regulatory Impact Analyses

A. Statement of Need

This proposed rule meets the requirements of our regulations at § 418.306(c), which requires annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of Core-Based Statistical Areas (CBSAs), or previously used Metropolitan Statistical Areas (MSAs). This proposed rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2018 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended section 1814(i)(1)(C) of the Act such that for hospice payments for FY 2018, the market basket percentage increase shall be 1 percent. Finally, section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices and this rule discusses changes in the requirements for the hospice quality reporting program in accordance with section 1814(i)(5) of the Act.

B. Overall Impacts

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an increase of \$180 million in payments to hospices, resulting from the hospice payment update percentage of 1.0 percent. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2017 to FY 2018. Using the most recent data available at the time of rulemaking, in this case FY

2016 hospice claims data, we apply the current FY 2017 wage index and labor-related share values to the level of care per diem payments and SIA payments for each day of hospice care to simulate FY 2017 payments. Then, using the same FY 2016 data, we apply the proposed FY 2018 wage index and labor-related share values to simulate FY 2018 payments. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2) and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal

mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). We estimate that this rulemaking is “economically significant” as measured by the \$100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that, to the best of our ability presents the costs and benefits of the rulemaking.

C. Anticipated Effects

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than \$7.5 million to \$38.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. HHS’s practice in interpreting the RFA is to consider effects economically “significant” only if they reach a threshold of 3 to 5 percent or more of total revenue or total costs. The effect of the proposed FY 2018 hospice payment update percentage results in an overall increase in estimated hospice payments of 1.0 percent, or \$180 million. Therefore, the Secretary has determined that this proposed rule will not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This proposed rule only affects hospices. Therefore, the Secretary has determined that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates

require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2017, that threshold is approximately \$148 million. This proposed rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of \$148 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule under these criteria of Executive Order 13132, and have determined that it will not impose substantial direct costs on state or local governments.

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year’s proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year’s rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is \$90.16 per hour, including overhead and fringe benefits (https://www.bls.gov/oes/2015/may/naics4_621100.htm). Assuming an average reading speed, we estimate that it would take approximately 1.3 hours for the staff to review half of this proposed rule. For each hospice that reviews the rule, the estimated cost is \$117.21 (1.3 hours ×

\$90.16). Therefore, we estimate that the total cost of reviewing this regulation is \$7,032.60 (\$117.21 × 60 reviewers).

D. Detailed Economic Analysis

The proposed FY 2018 hospice payment impacts appear in Table 20. We tabulate the resulting payments according to the classifications in Table 20 (for example, facility type, geographic region, facility ownership), and compare the difference between current and proposed payments to determine the overall impact.

The first column shows the breakdown of all hospices by urban or rural status, census region, hospital-based or freestanding status, size, and type of ownership, and hospice base. The second column shows the number

of hospices in each of the categories in the first column.

The third column shows the effect of the annual update to the wage index. This represents the effect of using the proposed FY 2018 hospice wage index. The aggregate impact of this change is zero percent, due to the proposed hospice wage index standardization factor. However, there are distributional effects of the proposed FY 2018 hospice wage index.

The fourth column shows the effect of the proposed hospice payment update percentage for FY 2018. The proposed FY 2018 hospice payment update percentage of 1 percent is mandated by section 1814(i)(1)(C) of the Act, as amended by section 411(d) of the MACRA.

The fifth column shows the effect of all the proposed changes on FY 2018 hospice payments. It is projected that aggregate payments will increase by 1.0 percent, assuming hospices do not change their service and billing practices in response.

As illustrated in Table 20, the combined effects of all the proposals vary by specific types of providers and by location. For example, due to the changes proposed in this rule, the estimated impacts on FY 2018 payments range from a 0.9 percent decrease for hospices providing care in the rural outlying region to a 1.7 percent increase for hospices providing care in the urban Pacific region.

TABLE 20—PROJECTED IMPACT TO HOSPICES FOR FY 2018

(1)	(2)	(3)	(4)	(5)
	Number of providers	Updated wage data (%)	Proposed FY 2018 hospice payment update (%)	FY 2018 total change (%)
All Hospices	4,295	0.0	1.0	1.0
Urban Hospices	3,323	0.0	1.0	1.0
Rural Hospices	972	0.1	1.0	1.1
Urban Hospices—New England	134	−0.7	1.0	0.3
Urban Hospices—Middle Atlantic	249	0.1	1.0	1.1
Urban Hospices—South Atlantic	429	−0.3	1.0	0.7
Urban Hospices—East North Central	405	−0.1	1.0	0.9
Urban Hospices—East South Central	159	0.0	1.0	1.0
Urban Hospices—West North Central	229	−0.2	1.0	0.8
Urban Hospices—West South Central	648	0.0	1.0	1.0
Urban Hospices—Mountain	315	−0.1	1.0	0.9
Urban Hospices—Pacific	716	0.7	1.0	1.7
Urban Hospices—Outlying	39	−0.6	1.0	0.4
Rural Hospices—New England	23	0.0	1.0	1.0
Rural Hospices—Middle Atlantic	40	0.6	1.0	1.6
Rural Hospices—South Atlantic	134	0.1	1.0	1.1
Rural Hospices—East North Central	140	0.2	1.0	1.2
Rural Hospices—East South Central	124	−0.1	1.0	0.9
Rural Hospices—West North Central	181	0.2	1.0	1.2
Rural Hospices—West South Central	180	0.1	1.0	1.1
Rural Hospices—Mountain	101	0.2	1.0	1.2
Rural Hospices—Pacific	46	0.3	1.0	1.3
Rural Hospices—Outlying	3	−1.9	1.0	−0.9
0—3,499 RHC Days (Small)	960	0.2	1.0	1.2
3,500—19,999 RHC Days (Medium)	2,001	0.1	1.0	1.1
20,000+ RHC Days (Large)	1,334	0.0	1.0	1.0
Non-Profit Ownership	1,058	0.0	1.0	1.0
For Profit Ownership	2,682	0.1	1.0	1.1
Government Ownership	155	−0.3	1.0	0.7
Other Ownership	400	−0.2	1.0	0.8
Freestanding Facility Type	3,323	0.0	1.0	1.0
HHA/Facility-Based Facility Type	972	0.0	1.0	1.0

Source: FY 2016 hospice claims from the Chronic Condition Data Warehouse (CCW) Research Identifiable File (RIF) in January 2017.

Region Key: New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Middle Atlantic=Pennsylvania, New Jersey, New York; South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin; East South Central=Alabama, Kentucky, Mississippi, Tennessee; West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; West South Central=Arkansas, Louisiana, Oklahoma, Texas; Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; Pacific=Alaska, California, Hawaii, Oregon, Washington; Outlying=Guam, Puerto Rico, Virgin Islands

E. Alternatives Considered

Since the hospice payment update percentage is determined based on statutory requirements, we did not consider not updating hospice payment rates by the payment update percentage. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage for that FY. Section 3401(g) of the Affordable Care Act also mandates that, starting with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. In addition, section 3401(g) of the

Affordable Care Act mandates that in FY 2013 through FY 2019, the hospice payment update percentage will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act). For FY 2018, since the hospice payment update percentage is determined based on statutory requirements at section 1814(i)(1)(C) of the Act, as amended by section 411(d) of the MACRA, we cannot consider not updating the hospice payment rates by the hospice payment update percentage, nor can we consider updating the hospice payment rates by the hospice payment update percentage absent the change to section 1814(i)(1)(C) as amended by MACRA.

F. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 21, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 21 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this proposed rule. This estimate is based on the data for 4,295 hospices in our impact analysis file, which was constructed using FY 2016 claims available in January 2017. All expenditures are classified as transfers to hospices.

TABLE 21—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM FY 2017 TO FY 2018

Category	Transfers
Annualized Monetized Transfers	\$ 180 million.*
From Whom to Whom?	Federal Government to Medicare Hospices.

* The net increase of \$180 million in transfer payments is a result of the 1.0 percent hospice payment update compared to payments in FY 2017.

G. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017 (82 FR 9339, February 3, 2017). Section 2(a) of Executive Order 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment, or otherwise promulgates, a new regulation. In furtherance of this requirement, section 2(c) of Executive Order 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations. OMB’s implementation guidance, issued on April 5, 2017, explains that “Federal spending regulatory actions that cause only income transfers between taxpayers and program beneficiaries (for example,

regulations associated with . . . Medicare spending) are considered ‘transfer rules’ and are not covered by EO 13771. . . . However . . . such regulatory actions may impose requirements apart from transfers . . . In those cases, the actions would need to be offset to the extent they impose more than de minimis costs. Examples of ancillary requirements that may require offsets include new reporting or recordkeeping requirements.” It has been determined that this proposed rule is a transfer rule that does not impose more than de minimis costs as described above and thus is not a regulatory action for the purposes of EO 13771.

H. Conclusion

We estimate that aggregate payments to hospices in FY 2018 would increase by \$180 million, or 1.0 percent, compared to payments in FY 2017. We estimate that in FY 2018, hospices in urban and rural areas would experience, on average, 1.0 percent and 1.1 percent increases, respectively, in estimated

payments compared to FY 2017. Hospices providing services in the urban Pacific and rural Middle Atlantic regions would experience the largest estimated increases in payments of 1.7 percent and 1.6 percent, respectively. Hospices serving patients in urban areas in the New England region would experience, on average, the lowest estimated increase of 0.3 percent in FY 2018 payments.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Dated: April 12, 2017.

Seema Verma,
Administrator, Centers for Medicare & Medicaid Services.

Dated: April 17, 2017.

Thomas E. Price,
Secretary, Department of Health and Human Services.

[FR Doc. 2017-08563 Filed 4-27-17; 4:15 pm]

BILLING CODE 4120-01-P