

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1692–F]

RIN 0938–AT26

Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

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

ACTION: Final rule.

SUMMARY: This final rule updates the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2019. The rule also makes conforming regulations text changes to recognize physician assistants as designated hospice attending physicians effective January 1, 2019. Finally, the rule includes changes to the Hospice Quality Reporting Program.

DATES: These regulations are effective on October 1, 2018.

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, send your inquiry via email to: hospicepolicy@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose

This final rule updates the hospice payment rates for fiscal year (FY) 2019, as required under section 1814(i) of the Social Security Act (the Act). This rule also revises the hospice regulations as a result of section 51006 of the Bipartisan Budget Act of 2018, which amended section 1861(dd)(3)(B) of the Act such that, effective January 1, 2019, physician assistants (PAs) will be recognized as designated hospice attending physicians in addition to physicians and nurse practitioners. Finally, this rule includes changes to 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, 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.B.1 of this rule 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 of this final rule, we discuss the FY 2019 hospice payment update percentage of 1.8 percent. Sections III.B.3 and III.B.4 of this final rule update the hospice payment rates and hospice cap amount for FY 2019 by the hospice payment update percentage discussed in section III.B.2 of this final rule. We also include regulations text changes in section III.C and section III.D pertaining to the definition of “attending physician” and “cap period.”

Finally, in section III.E of this rule, we discuss updates to the HQRP, including: Data review and correction timeframes for data submitted using the HIS; extension of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey participation requirements, exemption criteria and public reporting policies to future years; procedures to announce quality measure readiness for public reporting and public reporting timelines; removal of routine public reporting of the 7 HIS measures; and public display of public use file data on the Hospice Compare website.

C. Summary of Impacts

The overall economic impact of this final rule is estimated to be \$340 million in increased payments to hospices during FY 2019.

D. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for CMS. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.¹ This

¹ Meaningful Measures web page: [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-](https://www.cms.gov/Medicare/Quality-Initiatives-Patient)

initiative is one component of our agency-wide Patients Over Paperwork Initiative,² which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that fosters operational efficiencies, and it will reduce costs, including collection and reporting burden, while producing quality measurement that is more focused on meaningful outcomes.

The Meaningful Measures Framework has the following objectives:

- Address high-impact measure areas that safeguard public health;
- Patient-centered and meaningful to patients;
- Outcome-based where possible;
- Fulfill each program’s statutory requirements;
- Minimize the level of burden for health care providers (for example, through a preference for EHR-based measures where possible, such as electronic clinical quality measures³);
- Significant opportunity for improvement;
- Address measure needs for population based payment through alternative payment models; and
- Align across programs and/or with other payers.

In order to achieve these objectives, we have identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities as shown in the Table 1 below.

Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.

² See Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit, as prepared for delivery on October 30, 2017: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html>.

³ See section VIII.A.8.c. of the preamble of this final rule where we solicited comments on the potential future development and adoption of eCQMs.

TABLE 1—MEANINGFUL MEASURES

Quality priority	Meaningful measure area
Making Care Safer by Reducing Harm Caused in the Delivery of Care Strengthen Person and Family Engagement as Partners in Their Care	Healthcare-Associated Infections. Preventable Healthcare Harm. Care is Personalized and Aligned with Patient’s Goals. End of Life Care according to Preferences. Patient’s Experience of Care.
Promote Effective Communication and Coordination of Care	Patient Reported Functional Outcomes. Medication Management. Admissions and Readmissions to Hospitals. Transfer of Health Information and Interoperability.
Promote Effective Prevention and Treatment of Chronic Disease	Preventive Care. Management of Chronic Conditions. Prevention, Treatment, and Management of Mental Health. Prevention and Treatment of Opioid and Substance Use Disorders. Risk Adjusted Mortality.
Work with Communities to Promote Best Practices of Healthy Living	Equity of Care. Community Engagement.
Make Care Affordable	Appropriate Use of Healthcare. Patient-focused Episode of Care. Risk Adjusted Total Cost of Care.

By including Meaningful Measures in our programs, we believe that we can also address the following cross-cutting measure criteria:

- Eliminating disparities;
- Tracking measurable outcomes and impact;
- Safeguarding public health;
- Achieving cost savings;
- Improving access for rural communities; and
- Reducing burden.

We believe that the Meaningful Measures Initiative will improve outcomes for patients, their families, and health care providers while reducing burden and costs for clinicians and providers as well as promoting operational efficiencies.

We received numerous supportive comments from stakeholders regarding the Meaningful Measures Initiative and the impact of its implementation in CMS’ quality programs. Many of these comments pertained to specific program proposals, and are discussed in the appropriate program-specific sections of this final rule. Commenters also provided insights and recommendations for the ongoing development of the Meaningful Measures Initiative. We look forward to continuing to work with stakeholders to refine and further implement the Meaningful Measures Initiative, and will take commenters’ insights and recommendations into account moving forward.

E. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information

exchange to improve health care. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work collaboratively to advance interoperability across settings of care.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113 185) (IMPACT Act) requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers. To further progress toward the goal of interoperability, we are developing a Data Element Library to serve as a publically available centralized, authoritative resource for standardized data elements and their associated mappings to health IT standards. These interoperable data elements can reduce provider burden by allowing the use and reuse of healthcare data, support provider exchange of electronic health information for care coordination, person-centered care, and support real-time, data driven, clinical decision making. Once available, standards in the Data Element Library can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA).

The 2018 Interoperability Standards Advisory (ISA) is available at: <https://www.healthit.gov/standards-advisory>.

Most recently, the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, requires HHS to take new steps to enable the electronic sharing of health information, ensuring interoperability for providers and settings across the care continuum. Specifically, the Congress directed ONC to “develop or support a trusted exchange framework, including a common agreement among health information networks

nationally.” This framework (<https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement>) sets out a common set of principles for trusted exchange and minimum terms and conditions for trusted exchange in order to enable interoperability across disparate health information networks. In another important provision, the Congress established new authority for HHS to discourage “information blocking”, defined as practices likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information. We suggested that hospice providers learn more about these important developments and how they are likely to affect hospices.

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. 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 (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

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.

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.

Under the Medicare hospice benefit, the election of hospice care is a patient choice and once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group is essential in the seamless provision of services. These hospice services are provided primarily in the individual's home. 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.

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. Services Covered by the Medicare Hospice Benefit

Coverage under the Medicare Hospice benefit requires 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 also 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 FY 1983 Hospice Wage Index and Rate Update proposed rule (48 FR 38149), the hospice interdisciplinary group should comprise paid hospice employees as well as hospice volunteers, and that "the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices." This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end-of-life care.

C. 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 42 CFR 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), CHC, IRC, and general inpatient care (GIP)), 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 and items 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 changes in the methodology concerning updating the daily payment rates based on the hospital market basket percentage increase applied to the payment rates in effect during the previous federal fiscal year.

2. Balanced Budget Act of 1997

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) established that updates to the hospice payment rates beginning FY 2002 and subsequent FYs be the hospital market basket percentage increase for the FY.

3. FY 1998 Hospice Wage Index Final Rule

The FY 1998 Hospice Wage Index final rule (62 FR 42860), implemented a new methodology for calculating the hospice wage index and instituted an annual Budget Neutrality Adjustment Factor (BNAF) so aggregate Medicare payments to hospices would remain budget neutral to payments calculated using the 1983 wage index.

4. FY 2010 Hospice Wage Index Final Rule

The FY 2010 Hospice Wage Index and Rate Update final rule (74 FR 39384) instituted an incremental 7-year phase-out of the BNAF beginning in FY 2010 through FY 2016. The BNAF phase-out reduced the amount of the BNAF increase applied to the hospice wage index value, but 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 Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148), 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 PPACA, 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 FY 2011 Hospice Wage Index 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 PPACA, 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 PPACA 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

In the FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314) we announced that beginning in 2012, 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 through 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. 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

The FY 2015 Hospice Wage Index and 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 within 5 calendar days after the effective date of the discharge/revocation (unless the hospice has already filed a final claim) through the submission of a final claim or a Notice of Termination or Revocation (NOTR).

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50479) also 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.

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 Rate Update final rule (79 FR 50496) provided background, eligibility criteria, survey respondents, and implementation of the Hospice Experience of Care Survey for informal caregivers, that hospices are required to use as of 2015.

Finally, the FY 2015 Hospice Wage Index and 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 contractor (79 FR 50503).

8. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185) 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 Wage Index and Rate Update final rule (80 FR 47172), 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. 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 Rate Update final rule (80 FR 47186) 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

thereafter. Finally, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47144) 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.

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

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52160), we finalized several new policies and requirements related to the HQRP. First, we codified our policy that if the National Quality Forum (NQF) made non-substantive changes to specifications for HQRP measures as part of the NQF’s re-endorsement process, we would continue to utilize the measure in its new endorsed status, without going through new notice-and-comment rulemaking. We would 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 would 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 were 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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

requirements due to newness (81 FR 52182). The exemption is determined by CMS and is for 1 year only.

D. 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 1.5 million in FY 2017. Similarly, Medicare hospice expenditures have risen from \$2.8 billion in FY 2000 to approximately \$17.7 billion in FY 2017. Our Office of the Actuary (OACT) projects that hospice expenditures are expected to continue to increase, by approximately 8 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. While in 2002, lung cancer was the top principal diagnosis, neurologically based diagnoses have topped the list for the past 5 years. Additionally, 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; however, effective October 1, 2014, these diagnoses are no longer permitted as principal diagnosis codes on hospice claims. As a result of this, the most common hospice claims-reported diagnoses have changed from primarily cancer diagnoses to neurological and organ-based failure diagnoses. The top 20 most frequently hospice claims-reported diagnoses for FY 2017 are in Table 2 below.

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2017

Rank	ICD-10/reported principal diagnosis	Count	Percentage
1	G30.9 Alzheimer’s disease, unspecified	155,066	10
2	J44.9 Chronic obstructive pulmonary disease	77,758	5
3	I50.9 Heart failure, unspecified	69,216	4
4	G31.1 Senile degeneration of brain, not elsewhere classified	66,309	4
5	C34.90 Malignant Neoplasm Of Unsp Part Of Unsp Bronchus Or Lung	53,137	3
6	G20 Parkinson’s disease	40,186	3
7	G30.1 Alzheimer’s disease with late onset	38,710	2
8	I25.10 Atherosclerotic heart disease of native coronary art without angina pectoris	34,761	2
9	J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation	33,547	2
10	I67.2 Cerebral atherosclerosis	30,146	2
11	C61 Malignant neoplasm of prostate	25,215	2
12	I63.9 Cerebral infarction, unspecified	22,825	1
13	N18.6 End stage renal disease	21,549	1
14	C18.9 Malignant neoplasm of colon, unspecified	21,543	1
15	C25.9 Malignant neoplasm of pancreas, unspecified	20,851	1

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2017—Continued

Rank	ICD-10/reported principal diagnosis	Count	Percentage
16	I51.9 Heart disease, unspecified	18,794	1
17	I11.0 Hypertensive heart disease with heart failure	18,345	1
18	I67.9 Cerebrovascular disease, unspecified	18,234	1
19	I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease.	15,632	1
20	A41.9 Sepsis, unspecified organism	14,012	1

Note(s): The frequencies shown represent beneficiaries that had a least one claim with the specific 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 2017 hospice claims data from the CCW, accessed and merged with ICD-10 codes on January 10, 2018.

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47201), 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 2017 hospice claims show that 100 percent of hospices reported more than one diagnosis, 89 percent submitted at least two diagnoses, and 81 percent included at least three diagnoses.

III. Provisions of the Final Rule

On May 8, 2018, we published the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements proposed rule in the **Federal Register** (83 FR 20934 through 20970) and provided a 60-day comment period. In that proposed rule, we proposed to update the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2019. In addition, we proposed regulations text changes to recognize physician assistants as designated hospice attending physicians effective January 1, 2019. Finally, we proposed changes to the Hospice Quality Reporting Program. We received 56 public comments on the proposed rule, including comments from hospice agencies, national provider associations, patient organizations, nurses, and advocacy groups.

Below we provide a summary of each proposed provision, a summary of the public comments received and our responses to them, and the policies we are finalizing in the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule.

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

In the FY 2019 Hospice Wage Index and Payment Rate Update proposed rule (83 FR 20934), we provided a summary of analysis conducted on hospice length of stay, live discharge rates, skilled visits in the last days of life, and non-

hospice spending. Additionally, we discussed initial analyses of data from recently revised cost reports. We will continue to monitor the impact of future payment and policy changes and will provide the industry with periodic updates on our analysis in future rulemaking and/or announcements on the Hospice Center web page at: <https://www.cms.gov/Center/Provider-Type/Hospice-Center.html>.

We received comments on the hospice monitoring analysis and CMS's plans for future monitoring efforts with regard to hospice payment reform outlined in the proposed rule. The comments and our responses are described below:

Comment: Commenters expressed continued support for our plans to monitor the impact of hospice payment reform and suggested the use of monitoring results in order to better target program integrity efforts. One commenter suggested that providers would benefit from CMS providing data assessing the impact of the payment changes that occurred in early 2016 and the degree to which they are on track with the re-distributional impact that CMS anticipated as a part of its modeling. A commenter suggested that CMS focus on short lengths of stays in hospice rather than long length of stays as long length of stays, which could be an indicator of problematic behavior, noting that the median length of stay has remained constant at 18 days, and the commenter suggested that the focus of analysis should be on beneficiary access to hospice services. One commenter recommended that CMS revisit and clarify what should be covered under the hospice per diem, noting that clarification would enhance care for patients and families, allow for easier comparison of programs, and allow for increased program integrity efforts based on this data point. Finally, a few commenters noted concerns with increased scrutiny of claims for GIP care and the variability of costs for GIP care depending on whether the hospice provides the care in a facility or contracts with another entity.

Commenters suggested that CMS provide further education and clarification of acceptable GIP utilization for hospice providers as a means of encouraging them to provide the most appropriate level of care for the patient.

Response: We appreciate the comments provided regarding the ongoing analysis presented, and we plan continue to monitor hospice trends and vulnerabilities within the hospice benefit, while also investigating the means by which we can educate the provider community regarding the hospice benefit and appropriate billing practices. We will also consider these suggestions for future monitoring efforts, program integrity, and for potential policy or payment refinements. Additionally, we refer readers to sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, our regulations in the Code of Federal Regulations (CFR) 42 CFR part 418, which 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 and the CMS Hospice Center web page for more information (<https://www.cms.gov/Center/Provider-Type/Hospice-Center.html>).

Comment: Several commenters recommended that CMS move to implement additional Level 1 edits for the hospice cost reports in order to address existing gaps in data collection to meet minimum standards of accuracy. In addition, many commenters suggested that CMS should wait until the latest cost report changes (including imposition of additional Level 1 edits) are reflected in the data to ensure greater accuracy of data inputs.

Response: We appreciate support of the Level 1 edits to further address accuracy in cost reporting. As several commenters noted, on April 13, 2018, CMS issued Transmittal 3 revising the Medicare Provider Reimbursement

Manual—Part 2, Provider Cost Reporting Forms and Instructions, Chapter 43, Form CMS–1984–14. Transmittal 3 made several changes to the Hospice Cost Report, including the imposition of Level 1 and Level 2 edits (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3P243.pdf>). These changes are effective for cost reporting periods ending on or after December 31, 2017. We will continue to analyze Medicare hospice cost report data as it becomes available in determining whether additional hospice payment reform changes are needed to better align hospice payments with costs.

B. FY 2019 Hospice Wage Index and Rate Update

1. FY 2019 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 Office of Management and Budget (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 2019, the hospice wage index will be based on the FY 2018 hospital pre-floor, pre-reclassified wage index. This means that the hospital wage data used for the hospice wage index are 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 RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the Core-Based Statistical Areas (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 2019, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia.

In the FY 2008 Hospice Wage Index final rule (72 FR 50214), we adopted a policy for instances where there are rural areas without rural hospital wage data. In such instances, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous 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 2019, we proposed to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

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

Combined Statistical Areas, and guidance on uses of the delineation in these areas. In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47178), we adopted the OMB's new area delineations using a 1-year transition. In that final rule, we stated that beginning October 1, 2016, the wage index for all hospice payments would be fully based on the new OMB delineations.

On August 15, 2017, OMB issued bulletin No. 17–01, which is available at <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/bulletins/2017/b-17-01.pdf>. In this bulletin, OMB announced that one Micropolitan Statistical Area, Twin Falls, Idaho, now qualifies as a Metropolitan Statistical Area. The new CBSA (46300) comprises the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho. The FY 2019 hospice wage index value for CBSA 46300, Twin Falls, Idaho, will be 0.8000.

The hospice wage index applicable for FY 2019 (October 1, 2018 through September 30, 2019) is available on our website at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html>.

A summary of the comments we received regarding the wage index and our responses to those comments appear below:

Comment: A commenter stated that in FY 2018, the wage index for Spokane, WA had increased, which helped increase wages for employees and reduced turnover. However, the commenter noted that in the FY 2019 proposed rule, this increase is reversing. The commenter stated that using older wage index data, not allowing reclassification, and not accounting for outward migration speaks to the need for wage index reform for the hospice payment system. One commenter stated that in rural Kentucky and Indiana, the costs of providing hospice care exceed Medicare payments. The commenter further asserted that a lower reimbursement rate for rural areas when compared to urban areas is not sensible, given that urban areas have infrastructure that facilitates access to care. Another commenter expressed concern with the continued use of the pre-floor, pre-reclassified hospital wage index to adjust the hospice payment rates and stated that this causes continued volatility of the hospice wage index from one year to the next. The commenter stated that the volatility is often based on inaccurate or incomplete hospital cost report data.

Response: The annual changes in the wage index reflect real variations in costs of providing care in various

geographic locations. We utilize efficient means to ensure and review the accuracy of the hospital cost report data and resulting wage index. The hospice wage index is derived from the pre-floor, pre-reclassified wage index, which is calculated based on cost report data from hospitals. All Inpatient Prospective Payment System (IPPS) hospitals must complete the wage index survey (Worksheet S-3, Parts II and III) as part of their Medicare cost reports. Cost reports will be rejected if Worksheet S-3 is not completed. In addition, our Medicare contractors perform desk reviews on all hospitals' Worksheet S-3 wage data, and we run edits on the wage data to further ensure the accuracy and validity of the wage data. Our review processes result in an accurate reflection of the applicable wages for the areas given. In addition, we finalized a hospice wage index standardization factor in FY 2017 to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data. Applying a wage index standardization factor to hospice payments will eliminate the aggregate effect of annual variations in hospital wage data. Our policy of utilizing a hospice wage index standardization factor provides a safeguard to the Medicare program as well as to hospices because it will mitigate fluctuations in the wage index by ensuring that wage index updates and revisions are implemented in a budget neutral manner.

We note that the current statute and regulations that govern the hospice payment system do not currently provide a mechanism for allowing hospices to seek geographic reclassification. The reclassification provision is found in section 1886(d)(10)(C)(i) of the Act, which states, "The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospital's geographic classification . . ." This provision is only applicable to hospitals as defined in section 1886(d) of the Act. In addition, we do not believe that using hospital reclassification data would be appropriate, as these data are specific to the requesting hospitals and they may or may not apply to a given hospice.

Comment: One commenter expressed concern that the proposed FY 2019 hospice wage index will be based on the OMB geographic area wage delineations. The commenter was particularly concerned with the New York City CBSA and the fact that the CBSA contains counties from New Jersey where labor costs are lower.

Response: The OMB's CBSA designations reflect the most recent available geographic classifications and are a reasonable and appropriate method of defining geographic areas for the purposes of wage adjusting the hospice payment rates.

Comment: One commenter expressed concern that hospices in Montgomery County, Maryland, which are included in CBSA 43524 (Silver Spring-Frederick-Rockville, MD), are reimbursed at a lower rate than hospices in the greater Washington DC area that are included in CBSA 47894 (Washington-Arlington-Alexandria, DCVA-MD-WV). The commenters request that CMS reconsider CBSA 43524 (Silver Spring-Frederick-Rockville, MD).

Response: CBSA delineations are determined by the OMB. The OMB reviews its Metropolitan Area definitions preceding each decennial census to reflect recent population changes. The OMB's CBSA designations reflect the most recent available geographic classifications and were a reasonable and appropriate way to define geographic areas for purposes of wage index values. Ten years ago, in our FY 2006 Hospice Wage Index final rule (70 FR 45130), we finalized the adoption of the revised labor market area definitions as discussed in the OMB Bulletin No. 03-04 (June 6, 2003). In the December 27, 2000 **Federal Register** (65 FR 82228 through 82238), OMB announced its new standards for defining metropolitan and micropolitan statistical areas. According to that notice, OMB defines a CBSA, beginning in 2003, as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. The general concept of the CBSAs is that of an area containing a recognized population nucleus and adjacent communities that have a high degree of integration with that nucleus. The purpose of the standards is to provide nationally consistent definitions for collecting, tabulating, and publishing federal statistics for a set of geographic areas. CBSAs include adjacent counties that have a minimum of 25 percent commuting to the central counties of the area. This is an increase over the minimum commuting threshold for outlying counties applied in the previous MSA definition of 15 percent. Based on the OMB's current delineations, Montgomery County (along with Frederick County, Maryland) belongs in a separate CBSA from the areas defined in the

Washington-Arlington-Alexandria, DC-VA CBSA. Unlike IPPS, inpatient rehabilitation facility (IRF), and SNF, where each provider uses a single CBSA, hospice agencies may be reimbursed based on more than one wage index. Payments are based upon the location of the beneficiary for routine and continuous home care or the location of the agency for respite and general inpatient care. It is very likely that hospices in Montgomery County, Maryland provide RHC and CHC to patients in the "Washington-Arlington-Alexandria, DC-VA" CBSA in addition to serving patients in the "Baltimore-Columbia-Towson, Maryland" CBSA.

While CMS and other stakeholders have explored potential alternatives to the current CBSA-based labor market system (we refer readers to our website: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html>), no consensus has been achieved regarding how best to implement a replacement system. As discussed in the FY 2005 IPPS final rule (69 FR 49027), "While we recognize that MSAs are not designed specifically to define labor market areas, we believe they do represent a useful proxy for this purpose." We further believe that using the most current OMB delineations will increase the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels. We recognize that the OMB cautions that the delineations should not be used to develop and implement federal, state, and local nonstatistical programs and policies without full consideration of the effects of using these delineations for such purposes. As discussed in the OMB Bulletin No. 03-04 (June 6, 2003), The OMB stated that, "In cases where there is no statutory requirement and an agency elects to use the Metropolitan, Micropolitan, or Combined Statistical Area definitions in nonstatistical programs, it is the sponsoring agency's responsibility to ensure that the definitions are appropriate for such use. When an agency is publishing for comment a proposed regulation that would use the definitions for a nonstatistical purpose, the agency should seek public comment on the proposed use."⁴ While we recognize that OMB's geographic area delineations are not designed specifically for use in nonstatistical programs or for program purposes, including the allocation of federal funds, we continue to believe that the

⁴ https://www.whitehouse.gov/wp-content/uploads/2017/11/bulletins_b03-04.pdf.

OMB's geographic area delineations represent a useful proxy for differentiating between labor markets and that the geographic area delineations are appropriate for use in determining Medicare hospice payments. In implementing the use of CBSAs for hospice payment purposes in our FY 2006 rule (70 FR 45130), we considered the effects of using these delineations. We have used CBSAs for determining hospice payments for 10 years (since FY 2006). In addition, other provider types, such as IPPS hospital, home health, SNF, IRF, and the ESRD program, have used CBSAs to define their labor market areas for the last decade.

Final Decision: After considering the comments received in response to the proposed rule and for the reasons discussed above, we are finalizing our proposal to use the pre-floor, pre-reclassified hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. For FY 2019, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2013 and before October 1, 2014 (FY 2014 cost report data).

The wage index applicable for FY 2019 is available on our website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html>. The hospice wage index for FY 2019 will be effective October 1, 2018 through September 30, 2019.

2. FY 2019 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 PPACA 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 ACA 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).

The hospice payment update percentage for FY 2019 is based on the inpatient hospital market basket update of 2.9 percent (based on IHS Global Inc.'s second-quarter 2018 forecast with historical data through the first-quarter 2018). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the inpatient hospital market basket update for FY 2019 of 2.9 percent must be reduced by a MFP adjustment as mandated by the PPACA (0.8 percentage point for FY 2019). The inpatient hospital market basket update for FY 2019 is reduced further by 0.3 percentage point, as mandated by the PPACA. In effect, the hospice payment update percentage for FY 2019 is 1.8 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/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-1984-14.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 would be proposed in future rulemaking and would be subject to public comments.

A summary of the comments we received regarding the payment update percentage and our responses to those comments appear below:

Comment: Several commenters noted their support of the hospice payment update percentage.

Response: We appreciate the comments in support of the hospice payment update percentage.

Comment: Several commenters stated that the FY 2019 payment update of 1.8 percent is inadequate. One commenter stated that the payment update is insufficient to sustainably cover the broad range of services and high-quality care that their members provide regardless of diagnosis, location and payment source. Another commenter suggested that the multifactor productivity (MFP) adjustment is not related to hospice care productivity, but instead, is a uniform adjustment factor that is being applied to all proposed prospective payment rate increases for 2019. The commenter suggests that CMS should identify and report specific productivity performances for each unique healthcare category. Another commenter expressed concern that the 1.8 percent increase would not cover the 2 percent decrease in reimbursement that would be imposed should sequestration be required in 2019.

Response: The hospice payment update percentage and the application of the MFP are required by statute, as previously described in detail in this section, and we do not have regulatory authority to alter the update. Likewise, sequestration is determined outside of CMS' authority and the hospice payment updates are statutory.

Final Decision: We are implementing the hospice payment update percentage as discussed in the proposed rule. Based on IHS Global Insight, Inc.'s updated forecast, the hospice payment update percentage for FY 2019 will be 1.8 percent for hospices that submit the required quality data and -0.2 percent (FY 2019 hospice payment update of 1.8 percent minus 2 percentage points) for hospices that do not submit the required quality data.

3. FY 2019 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 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 that final rule, we implemented a Service Intensity Add-on (SIA) payment for RHC 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 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 utilization data available at the time of rulemaking. For FY 2019, we calculated the SBNF using FY 2017 utilization data. For FY 2019, the SBNF that would apply to days 1 through 60 is calculated to be 0.9991. The SBNF that would apply to days 61 and beyond is calculated to be 0.9998.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 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 FY 2019 hospice wage index and compare it to our simulation of total payments using the FY 2018 hospice wage index. By dividing payments for each level of care using the FY 2019 wage index by payments for each level of care using the FY 2018 wage index, we obtain a wage index standardization factor for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP). The wage index standardization factors for each level of care are shown in the tables below.

The FY 2019 RHC rates are shown in Table 3. The FY 2019 payment rates for CHC, IRC, and GIP are shown in Table 4.

TABLE 3—FY 2019 HOSPICE RHC PAYMENT RATES

Code	Description	FY 2018 payment rates	SIA budget neutrality factor	Wage index standardization factor	FY 2019 hospice payment update	FY 2019 payment rates
651	Routine Home Care (days 1–60) ..	\$192.78	× 0.9991	× 1.0009	× 1.018	\$196.25
651	Routine Home Care (days 61+) ...	151.41	× 0.9998	× 1.0007	× 1.018	154.21

TABLE 4—FY 2019 HOSPICE CHC, IRC, AND GIP PAYMENT RATES

Code	Description	FY 2018 payment rates	Wage index standardization factor	FY 2019 hospice payment update	FY 2019 payment rates
652	Continuous Home Care; Full Rate = 24 hours of care; \$41.56 = FY 2019 hourly rate.	\$976.42	× 1.0034	× 1.018	\$997.38
655	Inpatient Respite Care	172.78	× 1.0007	× 1.018	176.01
656	General Inpatient Care	743.55	× 1.0015	× 1.018	758.07

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 PPACA. 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 FY 2019 rates for hospices that do not submit the required quality data would be updated by the FY 2019 hospice payment update percentage of 1.8 percent minus 2 percentage points. These rates are shown in Tables 5 and 6.

TABLE 5—FY 2019 HOSPICE RHC PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2018 payment rates	SIA budget neutrality factor	Wage index standardization factor	FY 2019 hospice payment update of 1.8% minus 2 percentage points = -0.2%	FY 2019 payment rates
651	Routine Home Care (days 1–60) ..	\$192.78	× 0.9991	× 1.0009	× 0.998	\$192.39
651	Routine Home Care (days 61+) ...	151.41	× 0.9998	× 1.0007	× 0.998	151.18

TABLE 6—FY 2019 HOSPICE CHC, IRC, AND GIP PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2018 payment rates	Wage index standardization factor	FY 2019 hospice payment update of 1.8% minus 2 percentage points = -0.2%	FY 2019 payment rates
652	Continuous Home Care; Full Rate = 24 hours of care; \$40.74 = FY 2019 hourly rate.	\$976.42	× 1.0034	× 0.998	\$977.78
655	Inpatient Respite Care	172.78	× 1.0007	× 0.998	172.56
656	General Inpatient Care	743.55	× 1.0015	× 0.998	743.18

A summary of the comments we received regarding the payment rates and our responses to those comments appear below:

Comment: Several commenters mentioned the SIA payment and stated that CMS should allow visits by Licensed Practical Nurses (LPNs) in the last 7 days of life to be eligible for SIA payment due to short length of stays and clinical demands of hospice patients.

Response: We finalized the SIA payment policy in the FY 2016 Hospice Wage Index and Payment Update final rule (80 FR 47141) and we did not solicit comments on a proposal to modify these policy parameters in the FY 2019 Hospice Wage Index and Payment Rate update proposed rule (83 FR 20934). However, we will continue to consider and monitor for potential refinements to this policy, including current monitoring efforts that were described in the FY 2019 Hospice Wage Index and Payment Rate Update proposed rule (83 FR 20934) in response to these policy changes, and we will take these comments into account as we continue to do so.

Final Decision: We are implementing the updates to hospice payment rates as discussed in the proposed rule.

4. Hospice Cap Amount for FY 2019

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (Pub. L. 113–185). 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 2019 cap year will be \$29,205.44, which is equal to the 2018 cap amount (\$28,689.04) updated by the FY 2019 hospice payment update percentage of 1.8 percent.

A summary of the comments we received regarding the hospice cap

amount and our responses to those comments appear below:

Comment: One commenter suggested resetting and lowering the cap amount by an additional 10 to 15 percent, which the commenter stated will help to keep intact the original intent of the hospice philosophy and shift the narrative back towards the spirit of the community.

Response: We appreciate the commenter’s suggestion that CMS should reset and lower the annual cap amount. However, the restriction set forth in section 1814(i)(2)(B) of the Act, as amended by section 3(d) of the IMPACT Act, does not give us discretion to adjust the cap amount.

Final Decision: We are implementing the changes to the hospice cap amount as discussed in the proposed rule.

C. Request for Information Update—Comments Related to Hospice Claims Processing

In the FY 2018 Hospice Wage Index and Rate Update proposed rule (82 FR 20789), we solicited public comments 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 specifically stated that we would not respond to the comment submissions in the FY 2018 final rule. Instead, we would review the submitted request for information comments and actively consider them as we develop future regulatory proposals or future sub-regulatory policy guidance. After reviewing all submitted responses to our requests for information in the FY 2018 proposed rule, one recommendation in particular warranted a revision to our current policy. Commenters suggested that CMS remove the requirement to report detailed drug data on the hospice claim as a way to reduce burden for hospices. We initially began asking for this information via Hospice Change Request 8358 in support of hospice payment reform (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service>

Payment/Hospice/Downloads/R2747CP.pdf).

In the FY 2019 Hospice Wage Index and Rate Update proposed rule, (83 FR 20953), we provided an update that effective October 1, 2018, we proposed to no longer require the reporting of detailed drug data on the hospice claim as this information is not currently used for quality, payment, or program integrity purposes. Rescinding this requirement could result in a significant reduction of burden to Medicare hospices, potentially reducing the number of line items on hospice claims by approximately 21.5 million, in aggregate. Therefore, in the FY 2019 proposed rule, we stated that we would allow hospice two options for reporting hospice drug information: (1) Hospice providers would have the option to continue reporting infusion pumps and drugs, with corresponding NDC information, on separate line items on hospice claims, though it is no longer mandatory to report it this way; or (2) Hospice providers can submit total aggregate DME and drug charges on the claim.

While the majority of commenters were supportive of this proposal and agreed that it would help to reduce regulatory burden, we did receive some comments primarily asking for more clarification regarding the options for reporting. A summary of the comments we received regarding this change in drug reporting and our responses to those comments appear below:

Comments: Several commenters wanted to know if they needed to choose one option, and others requested clarification regarding options for submission. Some commenters asked if the reporting method could be determined on a case by case basis or if all claims had to be submitted using the same reporting option, meaning whether some claims could be reported with detailed line item information while others reported in the aggregate. One commenter suggested that it could be easier to report in the aggregate, depending on the responsiveness of the

physician or pharmacy that was involved in the patient's care. One commenter requested clarification if the claim would include all DME or just infusion pumps and drugs that were an item of DME. One commenter asked if this process would account for potential delay from receiving invoices from pharmacies. Several commenters raised concerns about the costs associated with retraining personnel to accurately capture claims data and vendor activities to build software and reports. Several commenters also noted concerns regarding whether there would be sufficient time for training and software revisions and testing prior to implementation.

Response: We appreciate the commenters' feedback regarding this sub-regulatory change. We will allow hospices two options for reporting hospice drug information. Providers will have the option to continue to report infusion pumps and drugs, with corresponding NDC information, on the hospice claim as separate line items. This submission option will no longer be mandatory. Alternatively, hospices can submit total, aggregate DME and drug charges on the claim. At this time, there is no claims processing edit prohibiting providers to submit both separate line item drug data and aggregate drug data on the claim. However, we encourage providers to select one consistent mechanism for reporting this data. In order to implement this change, we have issued a detailed sub-regulatory change request, effective October 1, 2018, that provides further guidance. Change Request 10573 and related educational materials are available for review at the following URL: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4035CP.pdf>.

We received several comments that were outside the scope of the CY 2019 Hospice Wage Index and Rate Update proposed rule. We received comments regarding the timely posting of beneficiary's hospice status in the Medicare system and the communication process between the CWF and the Part D MarX system, sequential billing, feedback on working with the Quality Improvement Organizations (QIOs) on beneficiary appeals of hospice discharges, the role of recreational therapy under the Medicare hospice benefit, and utilization of CHC and the midnight-midnight rule.

We thank commenters for their feedback and we will consider these suggestions for potential policy refinements. As we stated in the FY

2018 proposed rule, we will actively consider all input as we develop future regulatory proposals or future sub-regulatory policy guidance.

D. Regulations Text Changes in Recognition of Physician Assistants as Designated Attending Physicians

When electing the Medicare hospice benefit, the beneficiary agrees to forgo the right to have Medicare payment made for services related to the beneficiary's terminal illness and related conditions, except when such services are provided by the designated hospice and the beneficiary's designated attending physician as outlined in section 1812(d)(2)(A) of the Act. The designated attending physician plays an important role in the care of a Medicare hospice beneficiary. If a beneficiary designates an attending physician, the beneficiary or his or her representative acknowledges that the identified attending physician was his or her choice and that the attending physician identified by the beneficiary, at the time he or she elects to receive hospice care, has the most significant role in the determination and delivery of the individual's medical care. The designated attending physician is required to certify that the beneficiary is terminally ill and participates as a member of the hospice IDG that establishes and/or updates the individual's plan of care, ensuring that the Medicare beneficiary receives high quality hospice care.

Under the current regulations at § 418.3, the attending physician is defined as a doctor of medicine or osteopathy who is legally authorized to practice medicine or surgery by the state in which he or she performs that function, or a nurse practitioner, and is identified by the individual as having the most significant role in the determination and delivery of the individual's medical care. In the FY 2019 Hospice Wage Index and Rate Update proposed rule (83 FR 20953), we stated that section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) amended section 1861(dd)(3)(B) of the Social Security Act such that, effective January 1, 2019, physician assistants (PAs) will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. We proposed to change the definition of "attending physician" under § 418.3 to include physician assistants (PAs).

In the proposed rule, we also stated that, effective January 1, 2019, Medicare will pay for medically reasonable and necessary services provided by PAs to Medicare beneficiaries who have elected

the hospice benefit and who have selected a PA as their attending physician. PAs are paid 85 percent of the fee schedule amount for their services as attending physicians. Attending physician services provided by PAs may be separately billed to Medicare only if the PA is the beneficiary's designated attending physician, services are medically reasonable and necessary, services would normally be performed by a physician in the absence of the PA, whether or not the PA is directly employed by the hospice, and services are not related to the certification of terminal illness. Since PAs are not physicians, as defined in 1861(r)(1) of the Act, they may not act as medical directors or physicians of the hospice or certify the beneficiary's terminal illness and hospices may not contract with a PA for their attending physician services as described in section 1861(dd)(2)(B)(i)(III) of the Act, which sets out the requirements of the interdisciplinary group as including at least one physician, employed by or under contract with the agency or organization. All of these provisions apply to PAs without regard to whether they are hospice employees. We also proposed to amend 42 CFR 418.304 (Payment for physician and nurse practitioner services) in the regulations to include the details outlined above regarding Medicare payment for designated hospice attending physician services provided by physician assistants.

We solicited comments on the above proposals to expand the definition of "attending physician" at § 418.3 to include physician assistants (PA), and to amend the regulations at § 418.304 to allow payment for PA attending physician services. A summary of the comments and our responses to those comments are provided below:

Comment: Many commenters expressed support and appreciation for the inclusion of physician assistants as designated hospice attending physicians, as commenters noted that PAs have an important role in providing hospice care, including supplying care to rural areas, and believe that this change will increase access to hospice services for Medicare beneficiaries.

Response: We thank commenters for their support. Inclusion of PAs in the definition of attending physician for the Medicare hospice benefit will lead to more flexibility for hospice beneficiaries and providers alike.

Comment: Several commenters suggested aligning the nurse practitioner and physician assistant rules in regards to hospice face-to-face encounters and

certifying terminal illness. One commenter stated that the exclusion of PAs from being able to provide the face-to-face encounter falls short of the goals of expanding the number of providers assisting this vulnerable population. This commenter stated that allowing PAs to conduct the face-to-face encounter and to certify terminal illness ensures greater continuity of care and prevent patients from having to engage with another healthcare professional for this encounter. One commenter recommended that the regulations at § 418.22, which describe the requirements for the certification of terminal illness, be amended to include PAs. A commenter recommended that the regulations at § 418.22 be amended to add physician assistant.

Response: We appreciate commenters' suggestions that PAs be permitted to both perform hospice face-to-face encounters and certify terminal illness for hospice beneficiaries. As we described in the FY 2019 Hospice Wage Index and Rate Update proposed rule (83 FR 20953), the BBA of 2018 did not make changes to allow PAs to certify terminal illness or perform the face-to-face encounter for Medicare beneficiaries. In regards to the certification of terminal illness, section 51006 of the BBA of 2018 amended section 1814(a)(7)(A)(i)(I) of the Act explicitly to exclude physician assistants from certifying terminal illness. We reiterate that no one other than a medical doctor or doctor of osteopathy can certify or re-certify terminal illness. Additionally, PAs were not authorized by section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) to perform the required hospice face-to-face encounter for re-certifications. The hospice face-to-face encounter is required per section 1814(a)(7)(D)(i) of the Act, which continues to state that only a hospice physician or a hospice nurse practitioner can perform the encounter. We wish to note that the regulations at § 418.22 will continue to state that the hospice face-to-face encounter must be performed by a hospice physician or hospice nurse practitioner and that only a medical doctor or doctor of osteopathy can certify or re-certify terminal illness.

Comment: Several commenters suggested developing and supporting appropriate education and training programs for PAs and other clinicians who serve as attending physicians in hospice care to ensure that they have the experience and training needed to deliver quality end-of-life care to beneficiaries.

Response: We appreciate the commenter's interest in the

development of educational materials and programs for PAs regarding the role of the attending physician in the Medicare hospice benefit. We expect that providers will appropriately train staff according to the existing rules and regulations that govern Medicare hospice care and remain in compliance with state practice acts.

Comment: A few commenters noted that there may be issues regarding state hospice licensure requirements and the scope of practice of PAs as an individual state. The commenters note that some states may not allow PAs to serve as the hospice patient's attending physician, and these state laws and regulations would apply.

Response: We thank the commenter for noting that the states' scope of practice governance may not permit a PA to serve as a hospice beneficiary's attending physician. We note that hospice providers are responsible for reviewing the state hospice licensure requirements and scope of practice regulations for PAs to ensure that PAs are allowed to serve as a hospice patient's attending physician in accordance with state law and make staffing decisions accordingly.

Comment: One commenter stated that an advanced registered nurse practitioner (ARNP) and a PA cannot be a member of the hospice interdisciplinary group (IDG) other than as the attending physician. The commenter suggested that CMS continue exploring how these credentialed healthcare providers can work at the top of their licenses and assist providers in gaining efficiency and enhancing the members of the IDG.

Response: We thank the commenter for the comment regarding the composition of the IDG. The Condition of participation, "Interdisciplinary group, care planning, and coordination of services", described at § 418.56, states that "the hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient." Therefore, the attending physician, which could include an NP or a PA, does, in fact, play an essential role in the function of the IDG. Additionally, § 418.56 states "the interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles: (i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice). (ii) A registered nurse. (iii) A social worker. (iv) A pastoral or other counselor." The required members of

the IDG are described in the CoPs, but other professionals, including NPs and PAs, are not excluded from participating in the IDG as appropriate for the beneficiary's plan of care.

Final Decision: Effective for January 1, 2019, we are finalizing statutorily-required updates to the regulations to expand the definition of attending physician at § 418.3 to include physician assistants (PA). We are also finalizing amendments to the regulations at § 418.304 to include the details regarding Medicare payment for designated hospice attending physician services provided by physician assistants.

E. Proposed Technical Correction Regarding Hospice Cap Period Definition

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), we finalized aligning the cap period, for both the inpatient cap and the hospice aggregate cap, with the federal FY for FY 2017 and later. Therefore, the cap year now begins October 1 and ends on September 30 (80 FR 47186). We proposed to make a technical correction in § 418.3 to reflect the revised timeframes for hospice cap periods. Specifically, we proposed that § 418.3 would specify that the cap period means the twelve-month period ending September 30 used in the application of the cap on overall hospice reimbursement specified in § 418.309.

Additionally, we are making a technical correction in § 418.309 to reflect the revised timeframes for hospice cap periods. Specifically, we are inserting a reference to the definition of "cap period" as defined in § 418.3 and removing language setting out specific month and day information. We inadvertently did not propose to amend the regulations at § 418.309, but we now believe it is appropriate to make a technical correction to the regulations text; the specific changes we are making in the regulations simply codify the final policies previously finalized in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), and do not reflect any additional substantive changes.

Final Decision: We did not receive any comments on our proposed changes therefore, we are finalizing the changes to the regulations text regarding the hospice cap period as discussed in the proposed rule.

F. Updates to the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

The Hospice Quality Reporting Program includes HIS and CAHPS. 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 nor 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 Hospice QRP

a. Background

The “Meaningful Measures” initiative is intended to provide a framework for quality measurement and improvement work at CMS. While this framework serves to focus on those core issues that are most vital to providing high-quality care and improving patient outcomes, it also takes into account opportunities to reduce paperwork and reporting burden on providers associated with quality measurement. To that end, we have begun assessing our programs’ quality measures in accordance with the Meaningful Measures framework. We refer readers to the Executive Summary for more information on the “Meaningful Measures” initiative.

Comment: CMS received several comments that supported the Meaningful Measures Initiative. Additionally, commenters stated that the “Strengthen Person and Family Engagement as Partners in Their Care” Quality Priority, as set out in 83 FR 20935 is an important area that is

central to the provision of hospice care delivery. One commenter stated that the following Meaningful Measure Areas are applicable to hospice patients: End of Life Care according to Preferences, Patient’s Experience of Care, Patient Reported Functional Outcomes (83 FR 20935). One commenter stated that adverse event reporting in the hospice setting can be challenging due to the variety of levels and settings of care. CMS received a few comments regarding quality measure development processes. Commenters recommended that CMS seek stakeholder input as part of the quality measure development process. Additionally, measure development across all care settings should consider special populations such as those that are terminally ill, and that expected declines in functional status due to advanced illness should not negatively impact the provider. Further, CMS should pursue development of quality measures that are important for hospice patients at the end of life, such as person and family engagement, pain and symptom management, effective communication, care coordination, and care concordant with patients’ wishes. Finally, one commenter requested that CMS be transparent in its planning and development of potential HQRP quality measures and inform and engage stakeholders as frequently as possible.

Response: Since no changes were proposed regarding Meaningful Measures or quality measure development processes, comments received are outside the scope of the current rule. We discuss quality development processes in the FY 2018 Hospice final rule (82 FR 36652 through 36654), and we refer readers to that detailed discussion.

b. Accounting for Social Risk Factors in the Hospice QRP

In the FY 2018 Hospice Wage Index final rule (82 FR 36652 through 36654), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level, as set out annually in HHS guidelines, <https://www.federalregister.gov/documents/2018/01/18/2018-00814/annual-update-of-the-hhs-poverty-guidelines>, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is

related to the quality of health care.⁵ Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients as well as those with social risk factors receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in CMS value-based purchasing programs.⁶ As we noted in the FY 2018 Hospice Wage Index final rule (82 FR 36652 through 36654), ASPE’s report to Congress, which was required by section 2(d) of the IMPACT Act, found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. ASPE is continuing to examine this issue in its second report required by the IMPACT Act, which is due to Congress in the fall of 2019. In addition, as we noted in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38428), the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.⁷ The trial period ended in April 2017 and a final report is available at: http://www.qualityforum.org/SES_Trial_Period.aspx. The trial concluded that “measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship” between social risk factors and the outcomes measured. This discrepancy may be explained in part by the “methods used for adjustment and the limited availability of robust data on social risk factors”. NQF has extended

⁵ See, for example United States Department of Health and Human Services. “Healthy People 2020: Disparities. 2014.” Available at: <http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>; or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

⁶ Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), “Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs.” December 2016. Available at: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>.

⁷ Available at: http://www.qualityforum.org/SES_Trial_Period.aspx.

the socioeconomic status (SES) trial,⁸ allowing further examination of social risk factors in outcome measures.

In the FY 2018/CY 2018 proposed rules for our quality reporting and value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging CMS to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); considering the full range of differences in patient backgrounds that might affect outcomes; exploring risk adjustment approaches; and offering careful consideration of what type of information display would be most useful to the public.

We also sought public comment on confidential reporting and future public reporting of some of our measures stratified by patient dual-eligibility. In general, commenters noted that stratified measures could serve as tools for hospitals to identify gaps in outcomes for different groups of patients, improve the quality of health care for all patients, and empower consumers to make informed decisions about health care. We were encouraged to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned CMS to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

As discussed in last year's final rule, 82 FR 36652 through 36654, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details, where

we discuss the potential stratification of certain Hospital Inpatient Quality Reporting Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

Comment: CMS received several comments that supported the administration's continued investigation of ways that social risk factors can be applied to quality measure development. Several commenters recommended additional research on the inclusion of social determinants of health in the development of quality measures, especially for those that apply to the seriously and terminally ill population. Commenters also provided several recommendations for possible social risk factors, including native language of the patient, income level, race and ethnicity, adequacy of caregiver support, presence of PTSD, and number of facility-based patients.

Response: We appreciate commenters' continued support of our efforts to attain health equity for all beneficiaries. Since no changes were proposed to the social risk factors, comments received are outside the scope of the current rule. We addressed these issues in the FY 2018 final rule (82 FR 36652 through 36654), and we refer readers to that detailed discussion.

c. New Measure Removal Factor

In the FY 2016 Hospice Final Rule (80 FR 47186), we adopted seven factors for measure removal. We are adopting an eighth factor to consider when evaluating measures for removal from the HQRP measure set: The costs associated with a measure outweighs the benefit of its continued use in the program.

As we discussed in the Executive Summary, we are engaging in efforts to ensure that the HQRP measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. These costs are multifaceted and include not only the burden associated with reporting, but also the costs associated with complying with the program. We have identified several different types of costs, including, but not limited to: (1) Provider and clinician information collection burden and burden associated with the submitting/reporting of quality measures to CMS;

(2) the provider and clinician cost associated with complying with other Hospital IQR programmatic requirements; (3) the provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs; (4) the cost to CMS associated with the program oversight of the measure including measure maintenance and public display; and/or (5) the provider and clinician cost associated with compliance to other federal and/or state regulations (depending upon the measure). For example, it may be needlessly costly and/or of limited benefit to retain or maintain a measure for which our analyses show no longer meaningfully supports program objectives (for example, informing beneficiary choice or payment scoring). It may also be costly for health care providers to track the confidential feedback and preview reports, as well as publicly reported information on a measure we use in more than one program. We may also have to expend unnecessary resources to maintain the specifications for the measure, including the tools we need to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs. There also may be other burdens associated with a measure that arise on a case-by-case basis.

When these costs outweigh the evidence supporting the continued use of a measure in the HQRP, it may be appropriate to remove the measure from the program. Although we recognize that one of the main goals of the HQRP is to improve beneficiary outcomes by incentivizing health care providers to focus on specific care issues and making public data related to those issues, we also recognize that those goals can have limited utility where, for example, the publicly reported data is of limited use because it cannot be easily interpreted by beneficiaries and used to influence their choice of providers. In these cases, removing the measure from the HQRP may better accommodate the costs of program administration and compliance without sacrificing improved health outcomes and beneficiary choice.

We will remove measures based on this factor on a case-by-case basis. We might, for example, decide to retain a measure that is burdensome for health care providers to report if we conclude that the benefit to beneficiaries justifies the reporting burden. Our goal is to move the program forward in the least burdensome manner possible, while

⁸ Available at: <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86357>.

maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients.

We solicited public comment on our proposal to adopt an additional measure removal factor, “the costs associated with a measure outweighs the benefit of its continued use in the program,” beginning with the FY 2019 Hospice Wage Index final rule. The vast majority of commenters supported our proposal to adopt an eighth criterion for measure removal. Most commenters were appreciative of CMS acknowledging burden of measures as an important criterion for retaining measures in the HQRP. However, one commenter disagreed with this proposal as discussed further below. A summary of the comments we received on this proposal and our responses to those comments appear below:

Comment: Several commenters raised concerns and provided recommendations. Among those who supported the proposal, several commenters requested CMS seek public input before removing any measure from the HQRP under this criterion. Commenters noted that cost and benefits could be hard to define, and that interested parties may have different perspectives about relative costs versus benefits of a measure. Moreover, one commenter noted that benefits can be difficult to quantify (for example, timely care, good communication, quality of life). Thus, commenters recommended CMS seek public input prior to removing a measure based on this criterion in order to obtain meaningful stakeholder input on benefits of a measure, especially in instances where a measure may be costly, but provides value in distinguishing quality of hospice care. Commenters also recommended that if CMS decides a measure is appropriate for removal based on this criterion, that CMS announce removal of the measure through rulemaking.

Response: We appreciate the commenters input regarding the measure removal factor. We agree with commenters who suggested that CMS seek public input prior to removing measures under this measure removal factor. We value transparency in our processes, and continually seek stakeholder input through education and outreach sessions, other webinars, rulemaking, and other collaborative engagements with stakeholders. We intend to continue to adopt and remove measures through our previously identified processes, which include notice and comment rulemaking for

proposed adoption and removal of measures. The only exception to this is that we may immediately remove a measure from the Hospice Program if we identify the measure as having unintended consequences that may adversely affect patient safety.

Comment: The commenter who disagreed with this proposal stated that the existing seven criteria were sufficient for determining removal of a measure from the HQRP, and stated the eighth factor could open the door for providers to argue for dropping a measure they do not want collected for reasons other than true cost versus benefit concerns (for example, arguing to drop a measure they are performing poorly on by stating the measure’s costs outweigh the benefits).

Response: We agree that it is possible that providers may recommend removal of measures they do not support based on the case that these measures are costly. However, input from providers is only one element of our case-by-case analysis of measures. We also intend to consider input from other stakeholders, including patients, caregivers, advocacy organizations, healthcare researchers, and other parties as appropriate to each measure. We will weigh the input received from stakeholders with our own analysis of each measure to make a case-by-case determination of whether it’s appropriate to remove a measure based on its costs outweighing the benefit of its continued use in the program.

Overall, in our assessment of measure sets across quality reporting and value-based purchasing programs under the Meaningful Measure Initiative, we identified measures that were no longer sufficiently beneficial to justify their costs within their respective programs. However, none of the previously finalized measure removal factors applied to these measures. Therefore, we determined that our measure removal factors were incomplete without this newly identified factor.

Final Decision: After consideration of the comments, we are finalizing our proposal to adopt an additional measure removal factor for the HQRP, “the costs associated with a measure outweighs the benefit of its continued use in the program,” for FY 2019 and subsequent years.

3. Previously Adopted Quality Measures for FY 2019 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 National Quality Forum (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 2 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.

The Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission measure (hereafter referred to as “the Hospice Comprehensive Assessment Measure”) underwent an off-cycle review by the NQF Palliative and End-of-Life Standing Committee and successfully received NQF endorsement in July 2017.

Data for the Hospice Visits when Death is Imminent measure pair is being collected using new items added to the HIS V2.00.0, effective April 1, 2017. This one measure comprises a measure pair assessing hospice staff visits to patients at the end of life. Measure 1: Percentage of patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life. Measure 2: Percentage of patients receiving at least two visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses or hospice aides in the last 7 days of life. 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. We have begun analysis of the data, and, 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. We will use a similar process to analyze and submit new quality measures to NQF for endorsement in future years. Providers will be notified of measure endorsement

and public reporting through sub-regulatory channels.

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.F.5 of the

FY 2019 final rule for details regarding the CAHPS® Hospice Survey, including public reporting of selected survey measures.

TABLE 7—PREVIOUSLY FINALIZED QUALITY MEASURES AFFECTING THE FY 2019 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

NQF No.	Hospice item set quality measure	Year the measure was first adopted for use in APU determination
1641	Treatment Preferences	FY 2016
1647	Beliefs/Values Addressed (if desired by the patient)	FY 2016
1634	Pain Screening	FY 2016
1637	Pain Assessment	FY 2016
1639	Dyspnea Screening	FY 2016
1638	Dyspnea Treatment	FY 2016
1617	Patients Treated with an Opioid Who are Given a Bowel Regimen	FY 2016
3235	The Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	FY 2019
TBD	Hospice Visits when Death is Imminent	FY 2019

A summary of the comments we received regarding Hospice Visits and our response to those comments appear below:

Comment: CMS received several comments pertaining to the Hospice Visits when Death is Imminent Measure Pair. Even though commenters supported the Hospice Visits when Death is Imminent Measure Pair, they recommended updates to Measure Pair, such as excluding patients with a length of stay of 7 days or less, aligning the measure pair and the SIA reimbursement structure, and accounting for patient or family refusal of services in measure specifications.

Response: Since no changes were proposed to Hospice Visits when Death is Imminent Measure Pair, comments received are outside the scope of the current rule. We addressed these issues in the FY 2017 final rule (81 FR 52162 through 52169), and we refer the reader to that detailed discussion.

4. 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. Revised Data Review and Correction Timeframes for Data Submitted Using the HIS

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 on or after July 1, 2014. For each HQRP reporting year, we require that hospices submit data in accordance with the reporting requirements specified in the FY 2015 Hospice final rule (79 FR 50486) for the designated reporting period. Electronic submission is required for all HIS records. For more information about HIS data collection and submission policies and procedures, we refer readers to the FY 2018 Hospice Wage Index final rule (82 FR 36663) and the CMS HQRP website: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>. For more information about CAHPS® Hospice Survey data submission policies and timelines, we refer readers to section III.F.5 of the FY 2019 final rule.

Hospices currently have 36 months to modify HIS records. However, only data modified before the public reporting “freeze date” are reflected in the corresponding CMS Hospice Compare website refresh. For more information about the HIS “freeze date”, see the Public Reporting: Key Dates for Providers page on the CMS HQRP website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Key-Dates-for-Providers.html>.

To ensure that the data reported on Hospice Compare is accurate, we proposed that hospices be provided a

distinct period of time to review and correct the data that is to be publically reported. This approach would allow hospices a time frame in which they may analyze their data and make corrections (up until 11:59:59 p.m. ET of the quarterly deadline) prior to receiving their preview reports. Once the preview reports are received, it is infeasible to make corrections to the data underlying the quality measure scores that are to be made public. Therefore, we proposed that for data reported using the HIS that there be a specified time period for data review and a correlating data correction deadline for public reporting at which point the data is frozen for the associated quarter. Similar to the policies outlined in the FY 2016 SNF final rule (81 FR 24271) and the FY 2016 IPPS/LTCH final rule (80 FR 49754), at this deadline for public reporting, we proposed that data from HIS records with target dates within the correlating quarter become a frozen “snapshot” of data for public reporting purposes. Any record-level data correction after the date on which the data are frozen will not be incorporated into measure calculation for the purposes of public reporting on the CMS Hospice Compare website. For each calendar quarter of data submitted using the HIS, approximately 4.5 months after the end of each CY quarter we proposed a deadline, or freeze date for the submissions of corrections to records. We note that this new data correction deadline for HIS records is separate and apart from the established 30-day data submission deadline. More information about the data submission deadline can be found at <https://www.cms.gov/Medicare/Quality->

Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/

Specifically, each data correction deadline will occur on the 15th of the CY month that is approximately 4.5 months after the end of each CY quarter, and hospices will have up until 11:59:59 p.m. ET on that date to submit corrections or requests for inactivation of their data for the quarter involved. For example, for data reported in CY Q1, the freeze date will be August 15th, for CY Q2 the freeze date will be November 15th and so on. Under this policy, any modification to or inactivation of records that occur after the proposed correction deadline will not be reflected in publicly reported data on the CMS Hospice Compare website. For example, for the data collected during the 1st quarter, that is January 1st through March 31st of a

given year, the hospice will have until 11:59:59 p.m. ET on August 15th of that year to ensure all of their data is correct. Any modifications to first quarter data that are submitted to us after August 15th would not be reflected during any subsequent Hospice Compare refresh. We believe that this is a reasonable amount of time to allow providers to make any necessary corrections to submitted data prior to public reporting. This revised policy aligns HQRP with the policies and procedures that exist in our other quality reporting programs including the post-acute care programs, which also enable providers to review their data and make necessary corrections within the specified time frame of approximately 4.5 months following the end of a given CY quarter and prior to the public reporting of such data.

We proposed that beginning January 1, 2019, HIS records with target dates on or after January 1, 2019 will have a data correction deadline for public reporting of approximately 4.5 months after the end of each CY quarter in which the target date falls, and that hospices will have until 11:59:59 p.m. ET on the deadline to submit corrections.

We also proposed that for the purposes of public reporting, the first quarterly freeze date for CY 2019 data corrections will be August 15, 2019. To accommodate those HIS records with target dates prior to January 1, 2019 and still within a target period for public reporting, we also proposed to extend to hospices the opportunity to review their data and submit corrections up until the CY 19 Q1 deadline of 11:59:59 p.m. ET on August 15, 2019. Table 8 presents the proposed data correction deadlines for public reporting beginning in CY 2019.

TABLE 8—DATA CORRECTION DEADLINES FOR PUBLIC REPORTING BEGINNING CY 2019

Data reporting period*	Data correction deadline for public reporting*
Prior to January 1, 2019	August 15, 2019
January 1, 2019–March 31, 2019	August 15, 2019
April 1, 2019–June 30, 2019	November 15, 2019
July 1, 2019–September 30, 2019	February 15, 2020
October 1, 2019–December 31, 2019	May 15, 2020

* This CY time period involved is intended to inform both CY 2019 data and to serve as an illustration for the review and correction deadlines that are associated with each calendar year of data reporting quarter.

We received multiple comments pertaining to the revised data review and correction timeframes for data submitted using the HIS. A summary of the comments we received on this proposal and our responses to those comments appear below:

Comment: A majority of the commenters supported the proposed 4.5 month data correction deadline for publicly reported HIS data. Commenters noted that this timeframe was sufficient for providers to review their data and make necessary corrections prior to public reporting. One commenter questioned why CMS would create a shorter, 4.5 month timeframe for data corrections when hospices may submit claims for services up to 12 months from the date of service. This commenter suggested that quality data corrections should be permitted for a similar amount of time. Additionally, CMS received one comment that emphasized the importance of widespread provider education related to the data correction deadline for public reporting of HIS data. This commenter stated that providers may experience challenges submitting and

reviewing data in a shorter timeframe due to various circumstances, such as if the hospice is converting to a new EHR or if HIS data collection is not integrated into the hospice’s routine assessment.

Response: We appreciate the commenters’ support of a 4.5 month data correction deadline for publicly reported HIS data. CMS expects that the data that hospices submit to CMS is as accurate as possible upon the initial submission of that data, and that corrections should not be the rule, but rather the exception here. When a hospice does need to make a modification or inactivation requests, they will continue to be permitted for up to 36 months from the assessment target date. However, HIS data that are submitted more than 4.5 months from the end of the corresponding CY quarter will impact data displayed on Hospice Compare because that data will not be reflected in the hospices measure scores that are displayed on Hospice Compare. More information about modification and inactivation requests can be found in the HIS Manual (Section 3.6) available under the downloads section of the HIS web page on the CMS HQRP

website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>.

Requiring that data be reviewed and corrected for public reporting purposes within a defined period of time will result in more timely and accurate data on Hospice Compare, ensuring that consumers have access to a resource with consistent and accurate representations of hospice performance. We appreciate the commenter’s recommendation to align HQRP and claims policy. Although this new policy will not align HQRP and claims data submission requirements, it will align the HQRP with the policies and procedures that exist in other quality reporting programs including the post-acute care programs. Based on experiences in other settings, this timeframe allows hospices sufficient time to submit, review, and correct their data prior to public reporting of that data.

Finally, we agree that widespread education will be necessary to ensure that providers understand the data correction deadline for public reporting

of HIS data. We will provide future education and outreach activities to educate providers about the data correction deadline for public reporting through HQRP communication channels, which include postings on the CMS HQRP website, announcements in the MLN eNews, and Open Door Forums.

Final Decision: After consideration of the comments, we are finalizing our proposal to implement public reporting data review and correction timeframes for data submitted using the HIS, starting on January 1, 2019.

5. CAHPS® Hospice Survey Participation Requirements for the FY 2023 APU and Subsequent Years

The CAHPS® Hospice Survey of CMS' HQRP 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 may 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 patients' and informal caregivers' 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. In addition, the survey introduces standard survey administration protocols that allow for fair comparisons across hospices.

Although the development of the CAHPS® Hospice Survey predates the Meaningful Measures initiative, it used many of the Meaningful Measure principles in its development. The overarching quality priority of "Strengthen Person and Family Engagement as Partners in Their Care" includes Meaningful Measure areas such as "Care is personalized and Aligned with Patient's Goals," "End of Life Care According to Preferences" and "Patients Experience of Care." The survey questions were developed with input from caregivers of patients who died under hospice care. The survey focuses on topics that are meaningful to caregivers/patients and supports our efforts to put the patient and their family members first.

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 website: <https://www.HospiceCAHPSsurvey.org>, and in the CAHPS® Hospice Survey Quality Assurance Guidelines (QAG), which are posted on the website.

b. Overview of the CAHPS® Hospice Survey Measures

The CAHPS® Hospice Survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver (usually a family member) regarding the patient and family experience of care, unlike the Hospital CAHPS® Survey deployed in 2006 (71 FR 48037 through 48039) and other subsequent CAHPS® surveys. 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, getting help for symptoms, and interactions with hospice staff. The survey also contains 2 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 #2651). Measures derived from the CAHPS® Hospice Survey include 6 multi-item (composite) measures and 2 global ratings measures. They received NQF endorsement on October 26, 2016 (NQF #2651). We adopted these 8 survey-based measures for the CY 2018 data collection period and for subsequent years. These 8 measures are reported on Hospice Compare.

Comment: CMS received several comments relating to the range of responses to the CAHPS Survey. One commenter stated that the range of positive versus negative responses is too narrow. Another commented on the validity of a measure "when the national benchmark scores are all low in one area." This commenter also asks if anyone is evaluating these questions.

Response: We are continually analyzing the Hospice CAHPS to ensure there is sufficient variation to justify

their inclusion on Hospice Compare. Currently, the data show sufficient variability across hospices to justify their publication on Hospice Compare.

As part of our application for re-endorsement of the CAHPS® Hospice Survey Measures by the NQF next year (2019), the survey data will be fully analyzed again. The measures for the CAHPS® Hospice Survey are reviewed by NQF, the CAHPS Consortium, and the Measures Application Partnership (MAP) which is a joint program through HHS and the NQF.

We are uncertain what the commenter means by scores all being low in one area. We are not sure if this refers to the survey domain or a geographic region. Data may still be valid even if they demonstrate limited variability by domain or geographic area.

Final Decision: After consideration of the comments, we are finalizing our proposal to continue treating the preferred language of the caregiver as a recommended variable.

c. Data Sources

As discussed in the CAHPS® Hospice Survey QAG V4.0 (<http://www.hospiceCAHPSsurvey.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 2020, FY 2021, and FY 2022 APUs (82 FR 36673). We proposed to extend the same participation requirements to all future years, for example, the FY 2023, FY 2024 and FY 2025 Annual Payment and subsequent updates. To summarize, to meet the CAHPS® Hospice Survey requirements for the HQRP, we proposed 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.hospiceCAHPSsurvey.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.

Comment: One commenter suggested that we change the Quality Assurance Guidelines Manual for the CAHPS®

Hospice Survey so that the “preferred language” variable would become a required field for hospices to submit to CMS.

Response: We encourage hospices, with a significant caregiver population that speaks any of the languages the survey offers, to offer the CAHPS® Hospice Survey in all applicable languages. CMS also encourages hospices that serve patient populations that speak languages other than those noted to request that CMS create an official translation of the CAHPS® Hospice Survey in those languages. Send any requests to our technical assistance team at: hospicecahpsurvey@HCQIS.org or call them at: 1-844-472-4621. Currently the survey is offered in English and Spanish for the mail and telephone versions of the survey. In addition the mail survey is offered in the following languages: Traditional and simplified Chinese, Russian, Vietnamese, Portuguese, Polish and Korean. Approximately 99 percent of the hospice surveys are completed in English.

Final Decision: After consideration of the comments, we are finalizing our proposal to continue treating the preferred language of the caregiver as a recommended variable.

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. We solicited public comment on this proposal.

Comment: One commenter noted that validating their CAHPS Hospice survey data “against the files that are submitted to the vendor is a multiple day process, and if discrepancies are identified, often the timeline for survey submission etc. has expired and no way to get those days back.” This commenter further noted that there appear to be no repercussions for vendors who miss their data submission deadlines. The commenter also suggested that vendors also should have some responsibilities.

Response: We appreciate the commenter’s concerns about the process of submitting survey data to their vendor, however, we want to clarify that CMS has no legal authority to directly regulate survey vendors. We do encourage hospices to monitor their vendors by checking data submissions reports regularly to ensure that data are being submitted on time, and to hold their vendors accountable for performance issues.

Comment: Two commenters described expenses associated with participating in the CAHPS Hospice Survey as unfunded burdens. One commenter indicated that providing a reimbursement rate close to the actual market basket rate would ensure the availability of funds to meet the additional administrative burden of the survey. The other commenter indicates the survey places an unfunded burden on hospices and requests that CMS consider including an additional administrative reimbursement mechanism to help cover these costs.

Response: We take a number of steps to reduce the burden of the cost of participating in the CAHPS Hospice Survey. First, we exempt the smallest hospices from participating. Second, we approved a variety of modes of data collection (mail, telephone, and mail with telephone follow-up) which incur different costs. Third, we have approved a wide variety of vendors with different costs and mixed of services, so that hospices can choose the vendor that is most compatible with their needs.

Comment: One commenter suggested fast-tracking studies to compare responses and response rates of alternative modes of conducting the survey, including using tablets, text messages, and other real-time survey options.

Response: We have started examining the possibility of electronic survey options. What we have found out so far is that email or web-based surveys alone often have very low response rates. Electronic surveys would be useful mostly to supplement current survey modes. We are continuing to explore email and web alternatives. We are not currently considering so called “real-time” modes of survey administration, such as in-person interviews with tablets. In-person interviewing is very expensive if conducted by a third-party vendor. It runs the risk of significant bias if the survey is conducted by a hospice staff member. For these reasons, we do not believe these are appropriate techniques for the CAHPS® Hospice Survey. Text messaging is mostly useful for very short surveys or to provide a link to a web survey. We do not anticipate shortening our questionnaire to an extent that would be compatible with text messaging without a link. That said, we are continuing to examine the possibilities of using alternative survey methods across all of the CAHPS surveys.

Comment: One commenter suggested that CMS review cover letters and phone script introductions for the CAHPS Hospice Survey. They stated

that the current versions require too high a reading level.

Response: The CAHPS Hospice Survey team has recently decided to launch a study of the cover letter and phone script to determine how it can be made more readable to all members of the public. This research will include a review of the grade level of each item and feedback from respondents.

Final Decision: After consideration of the comments, we are finalizing our proposals to continuing to require that hospice providers use CMS-approved vendors to conduct the CAHPS® Hospice Survey using one of the three approved modes, mail, telephone or mixed mode (mail with telephone follow-up).

d. Public Reporting of CAHPS® Hospice Survey Results

We began public reporting of the results of the CAHPS® Hospice Survey on Hospice Compare as of February 2018. The first report of CAHPS® data covered survey results from deaths occurring between Quarter 2, 2015 and Quarter 1, 2017. We report the most recent 8 quarters of data on the basis of a rolling average, with the most recent quarter of data being added and the oldest quarter of data removed from the averages for each data refresh. We detailed the calculation of these measures in 82 FR 36674. We refresh the data 4 times a year in the months of February, May, August, and November. We will not publish CAHPS® data for any hospice that has fewer than 30 completed surveys, due to concerns about statistical reliability. We proposed to use the same public reporting policies in future years.

Comment: A couple of commenters suggested that CMS report more recent data for the CAHPS® Hospice Survey by reducing the number of quarters of data being reported.

Response: Currently, the CAHPS® Hospice Survey reports data on Hospice Compare using a rolling average of the eight most recent quarters of data. We use 8 quarters to maximize the number of hospices that are included on the Compare site. Among the 4,643 hospices on the active agency list for the most recent public reporting period (Q4 2015–Q3 2017), 61 percent (2,832) had 30 completes over 8 quarters (Q4 2015–Q3 2017) and 49 percent (2,262) had 30 completes over 4 quarters (Q4 2016–Q3 2017). For this reason, we plan to continue to report eight quarters of data.

Final Decision: After consideration of the comments, we are finalizing our proposal to continue to report eight quarters of data on Hospice Compare.

e. 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 (82 FR 36671). We proposed to continue our policy for a volume-based exemption for CAHPS® Hospice Survey Data Collection for FY 2023 and every year thereafter. For example, for the FY 2023 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2020 through December 31, 2020 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements (corresponds to the CY 2021 data collection period). To qualify, hospices must submit an exemption request form for the FY 2023 APU. The exemption request form is available on the official CAHPS® Hospice Survey website: <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, 2020 through December 31, 2020 (reference year). The due date for submitting the exemption request form for the FY 2023 APU is December 31, 2021. 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.

For FY 2024 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2021 through December 31, 2021 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements. 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, 2021 through December 31, 2021. The due date for submitting the exemption request form for the FY 2024 APU is

December 31, 2022. 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 must request the exemption annually for every applicable FY APU period.

For the FY 2025 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2022 through December 31, 2022 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements for the FY 2025 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, 2022 through December 31, 2022. The due date for submitting the exemption request form for the FY 2025 APU is December 31, 2023. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization must request the exemption annually for every applicable FY APU period.

TABLE 9—SIZE EXEMPTION KEY DATES FY 2023, FY 2024 AND FY 2025

Fiscal year	Data collection year	Reference year (count total number of unique patients in this year)	Size exemption form submission deadline
FY 2023	2021	2020	December 31, 2021.
FY 2024	2022	2021	December 31, 2022.
FY 2025	2023	2022	December 31, 2023.

We received no comments about the size exemption for hospices.

Final Decision: We are finalizing our proposal to exempt to small hospices from data collection for the CAHPS® Hospice Survey through FY 2015 and subsequent years.

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

We previously finalized a one-time newness exemption for hospices that meet the criteria (81 FR 52181). We proposed to continue the newness exemption for FY 2023, FY 2024, FY 2025, and all future years.

Specifically, hospices that are notified about their Medicare CCN after January 1, 2021 are exempted from the FY 2023 APU CAHPS® Hospice Survey requirements due to newness. Likewise, hospices notified about their Medicare CCN after January 1, 2022 are exempted from the FY 2024 APU CAHPS® Hospice Survey requirements due to newness. Hospices notified about their Medicare CCN after January 1, 2023 are

exempted from the FY 2025 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. We encourage hospices to keep the letter they receive providing them with their CCN. The letter can be used to show when you received your number.

We proposed that this newness exemption to the CAHPS® Hospice Survey will apply to all future years.

Comment: One commenter stated that they supported a number of the changes being made permanent in this rule, including the “newness” exemption from the CAHPS survey, as well as the annual exemption for very small programs.

Response: We appreciate the commenter’s support. We have been extending the newness exemption to hospices since data collection started in 2015. Hospices that received their CMS Certification Number (CCN) after the start of the data collection year (January

1) are exempted from data collection for that year. CMS identifies the hospices that qualify for the newness exemption. We plan to continue to offer the newness exemption without change.

Final Decision: After consideration of the comments, we are finalizing our proposal to continue offering the “newness” exemption for the CAHPS® Hospice Survey to hospices that receive their CCN number after the data collection year starts.

g. Requirements for the FY 2023 APU

To meet participation requirements for the FY 2023 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2021 through December 2021 (all 12 months) to receive their full payment for the FY 2023 APU. All data submission deadlines for the FY 2023 APU are in Table 10. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 10 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 10—CAHPS® HOSPICE SURVEY DATA SUBMISSION DATES FOR THE APU IN FY 2023, FY 2024, AND FY 2025

Sample months ¹ (month of death)	CAHPS Quarterly data submission deadlines ²
FY 2023 APU	
CY January–March 2021 (Quarter 1)	August 11, 2021.
CY April–June 2021 (Q2)	November 10, 2021.
CY July–September 2021 (Q3)	February 9, 2022.
CY October–December 2021 (Q4)	May 11, 2022.
FY 2024 APU	
CY January–March 2022 (Q1)	August 10, 2022.
CY April–June 2022 (Q2)	November 9, 2022.
CY July–September 2022 (Q3)	February 8, 2023.
CY October–December 2022 (Q4)	May 10, 2023.
FY 2025 APU	
CY January–March 2023 (Q1)	August 9, 2023.
CY April–June 2023 (Q2)	November 8, 2023.
CY July–September 2023 (Q3)	February 14, 2024.
CY October–December 2023 (Q4)	May 8, 2024.

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.

h. Requirements for the FY 2024 APU

To meet participation requirements for the FY 2024 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2022 through December 2022 (all 12 months) to receive their full payment for the FY 2024 APU. All data submission deadlines for the FY 2024 APU are in Table 10. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 10 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.

i. Requirements for the FY 2025 APU

To meet participation requirements for the FY 2025 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2023 through December 2023 (all 12 months) to receive their full payment for the FY 2025 APU. All data submission deadlines for the FY 2025 APU are in Table 10. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 10 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.

j. For Further Information About the CAHPS® Hospice Survey

We encourage hospices and other entities to learn more about the survey on: <https://www.hospiceCAHPSsurvey.org>. For direct questions, contact the CAHPS® Hospice Survey Team at hospiceCAHPSsurvey@HCQIS.org or telephone 1–844–472–4621.

6. 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 prior to such data being made public; the data will be available on our public website.

To meet the PPACA’s requirement for making quality measure data public, we launched the Hospice Compare website in August 2017. This website allows consumers, providers, and other stakeholders to search for all Medicare-certified hospice providers and view their information and quality measure

scores. Since its release, the CMS Hospice Compare website has reported 7 HIS Measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617). In February 2018, CAHPS® Hospice Survey measures (NQF #2651) were added to the website.

a. Adding Quality Measures to Publically Available Websites—Procedures To Determine Quality Measure Readiness for Public Reporting

Quality measures are added to Hospice Compare once they meet readiness standards for public reporting, which is determined through the following processes.

First, we assess the reliability and validity of each quality measure to determine the scientific acceptability of each measure. This acceptability analysis is the first step in determining a measure’s readiness for public reporting. We evaluate the quality measures using the NQF Measure Evaluation Criteria found on the NQF website here: http://www.qualityforum.org/Measuring_Performance/Submitting_Standards/Measure_Evaluation_Criteria.aspx#scientific. Analyses to assess scientific acceptability of new measures are important to determine if the measure produces reliable and credible results when implemented.

Reliability testing demonstrates that a measure is correctly specified by ensuring that “measure data elements are repeatable, producing the same results a high proportion of time when assessed in the same population in the same time period and/or that the measure score is precise.” Validity testing demonstrates that measure specifications are consistent with the focus of the measure and that the measure score can accurately distinguish between quality of care provided by providers. Reliability and validity are tested at both the data item and quality measure levels. For example, at the item-level, we examine the missing data rate and cross validate the data elements between the assessment data and Medicare claims to ensure validity of the data elements. At the quality measure level, we conduct split-half analysis, consistency analysis across time, stability analysis, and signal-to-noise analysis to demonstrate the reliability of the measures. We examine the relationships between different quality measures assessing similar quality areas to demonstrate the validity of the quality measures.

To establish reliability and validity of the quality measures, at least 4 quarters of data are analyzed. The first quarter of data after new adoption of, or changes to, standardized data collection tools may reflect the learning curve of the hospices; we first analyze these data separately to determine the appropriateness to use them to establish reliability and validity of quality measures.

To further inform which of the measures are eligible for public reporting, we then examine the distribution of hospice-level denominator size for each quality measure to assess whether the denominator size is large enough to generate the statistically reliable scores necessary for public reporting. The goal of this analysis is to establish the minimum denominator size for public reporting, which is referred to as reportability analysis. Reportability analysis is necessary because, if a hospice QM score is generated from a denominator that is too small, the observed measure score may be a biased assessment of the provider’s performance, yielding scores that are statistically unreliable. Thus, we have set a minimum denominator size for public reporting, as well as the data selection period necessary to generate the minimum denominator size for the CMS Hospice Compare website.

This approach to testing reliability, validity, and reportability of quality measures (QMs) is consistent with the

approach taken in other CMS quality reporting programs. Further, CMS provides hospices the opportunity to review their measures through their Certification and Survey Provider Enhanced Reports (CASPER) and additionally publishes the methodology related to the calculation of each quality measure in the Hospice Quality Measure User’s Manual, which is updated with the addition of each quality measure to the Hospice QRP. Since December 2016, two provider feedback reports have been available to providers: 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 for the purposes of internal provider quality improvement and are available to hospices on-demand. We encourage providers to use the CASPER QM Reports to review their HIS quality measures regularly to ensure submitted quality measure data is correct. For more information on the CASPER QM Reports, we refer readers to the CASPER QM Factsheet on the HQRP website at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.html>.

Because we follow the above outlined processes in determining the readiness for a quality measure to be publicly reported, and perform the necessary analysis to determine and demonstrate that our measures meet the NQF measure evaluation criteria prior to publicly reporting provider performance on these quality metrics, we proposed to announce to providers any future intent to publicly report an already-adopted quality measure on Hospice Compare or other CMS website, including timing, through sub-regulatory means.

Conducting these analyses and announcing measure timelines and readiness for public reporting through sub-regulatory channels will allow us to implement measures for public reporting in a more expeditious, yet still transparent manner, benefitting the public by providing QM data as soon as it is determined to meet the minimum standards for public reporting. We will continue to provide updates about public reporting of QMs through the normal CMS HQRP communication channels, including postings and announcements on the CMS HQRP website, MLN eNews communications, national provider association calls, and announcements on Open Door Forums. Note that we are not making any

changes to how CMS adopts substantive measures for the HQRP.

We received multiple comments on this proposal to announce to providers any future intent to publicly report a quality measure on Hospice Compare, including timing, through sub-regulatory means. A summary of the comments we received on this topic and our responses to those comments are below:

Comment: CMS received several comments on this proposal. Most commenters supported this proposal. Although commenters appreciated CMS’ interest to move measures to public reporting in an expeditious manner, several commenters had concerns about this proposal and several were not supportive of it. Those who conditionally supported this proposal requested CMS develop separate processes for announcing readiness for public reporting and public reporting timelines for NQF- vs. non-NQF-endorsed measures. Some commenters stated that this proposal had the potential to reduce opportunities for public input and decrease transparency. Specific concerns from commenters are addressed in further detail below:

Several commenters had concerns about this proposal; the majority of concerns stemmed from the desire to maintain transparency and opportunity for stakeholder input that CMS has established in the HQRP measure implementation processes to-date. Commenters appreciated CMS’ methodical approach to-date and expressed concern that, without proposing public reporting implementation dates through rulemaking, there may not be opportunity for providers to comment, provide input, or give feedback before a public reporting date is set. One commenter stated that a sub-regulatory process may fracture communication channels for conveying information to the public, limiting opportunity for review and input.

Apart from the annual rulemaking cycle, should CMS move forward with a sub-regulatory process, a couple of commenters suggested that CMS develop criteria that would guide CMS’ decision regarding which measures are displayed on Hospice Compare, and that regardless of the channel (regulatory or sub-regulatory), CMS consider public comments and feedback on quality measures proposed to be added to Hospice Compare to promote transparency and to solicit provider input.

Among conditionally supportive commenters, some recommended separate processes for NQF- vs non-

NQF-endorsed measures. Commenters stated that a sub-regulatory process would be appropriate for NQF-endorsed measures, as these measures will have undergone a thorough review process and the public will have had ample opportunity to comment on these measures. However, commenters stated that for measures that are not NQF-endorsed, it would be most appropriate for CMS to go through formal rulemaking processes prior to publishing these measures on Hospice Compare and for CMS to continue to submit such measures to public notice through rulemaking prior to any public display. Commenters suggested CMS to receive full stakeholder input through the rulemaking process on quality measures that are not NQF-endorsed.

Other comments received related to this proposal included a statement from one commenter that it is “too early” to implement a sub-regulatory process, given the relative newness of the HQRP and Hospice Compare. Additionally, a couple of commenters recommended that in addition to the processes described in the proposed rule for assessing readiness (validity and reliability testing, etc.) and the NQF endorsement processes, CMS implement a user testing process that enables CMS to identify those measures for which performance can be translated into reliable and actionable information for beneficiaries.

Response: We agree with commenters that a transparent process and allowing ample opportunity for public input prior to displaying a measure on Hospice Compare is a vital component of moving a measure from data collection to public reporting. We agree that stakeholder input is invaluable to this process, and our intent is to continue to communicate clearly with providers and continue to solicit their input on all aspects of the measure development lifecycle. As set out at section 1814(i)(5)(E) of the Act, the statutory requirements for public reporting of quality measures (1) allow providers an opportunity to review their data prior to public reporting of any data and (2) require CMS to display measures for public reporting. This is evidenced where the statute states: The “Secretary shall establish procedures for making data . . . available to the public” and “the Secretary shall report quality measures that relate to hospice care provided by hospice program on the internet website of the Medicare & Medicaid Services.” Now that we have communicated in this rule the procedure for determining readiness for public reporting through rulemaking, we can announce readiness and

timelines for publicly reporting measures through sub-regulatory channels. The annual rulemaking cycle is not the only channel by which information can be communicated to the public in a transparent and collaborative manner. Sub-regulatory channels can be equally effective and timelier at communicating information to the public. Therefore, we view this proposal not as a loss of opportunity for dialogue or transparency, but as a way to change the channel by which we communicate with the public to receive input on one specific aspect of the QM development and implementation lifecycle. Moreover, we stated that this process has the potential to improve timeliness of communication with the public as we would no longer have to wait for the annual rulemaking cycle to commence conversations about readiness for public reporting. The commenters’ concerns about transparency and public input can be addressed through sub-regulatory channels.

In the context of commenters’ concerns—especially those about NQF- vs. non-NQF-endorsed measures—we would like to clarify that this policy does not eliminate opportunities for providers to comment on the public reporting of newly adopted measures through rulemaking. Specifically, several commenters requested CMS “ensure there is a formal public notice and comment process prior to publishing the measures on Hospice Compare” and that CMS “continue to submit such [non-NQF-endorsed] measures to public notice through rulemaking prior to any public display”. We would like to clarify that this policy will not change how measures are adopted in the HQRP, only how we communicate when measures are ready to be displayed on Hospice Compare. New measures to be adopted in the HQRP will have been reviewed and supported by the consensus-based entity Measure Application Partnership, convened by the NQF, and the public can comment on the measures as part of that process. We will continue to propose measures (NQF- or non-NQF-endorsed) for adoption in the HQRP through the annual rulemaking process, which will allow opportunities for providers to comment—through rulemaking—on proposed measures. When measures are proposed for initial adoption through rulemaking, providers have the opportunity to voice concerns about any aspect of the proposed measure, including public reporting. Thus, this policy aligns with commenters who requested that CMS “ensure a formal public notice and

comment process prior to publishing measures on Hospice Compare” and that CMS “continue to submit such [non-NQF-endorsed] measures to public notice through rulemaking prior to any public display”.

Regarding comments on the process that CMS uses to determine readiness for Hospice Compare, we direct providers to the text in the proposed rule, 83 FR 20960, which outlines our process for determining readiness for public display (for example, validity and reliability analyses; reportability analysis), which does include a user testing process.

Final Decision: After consideration of the comments, we are finalizing our proposal to announce to providers any future intent to publicly report a quality measure on Hospice Compare or other CMS website, including timing, through sub-regulatory means.

b. Quality Measures To Be Displayed on Hospice Compare in FY 2019

We anticipate that we will begin public reporting of the HIS-based Hospice Comprehensive Assessment Measure (NQF #3235), a composite measure of the 7 original HIS Measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617), on the CMS Hospice Compare website in Fall 2018. For more information on how this measure is calculated, see the HQRP QM User’s Manual v2.00 in the “Downloads” section of the Current Measures page on the CMS HQRP website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>. The reporting period for which the measure will be displayed on the CMS Hospice Compare website will align with the currently established procedures for the 7 HIS measures. For more information about reporting periods, see the Public Reporting: Key Dates for Providers page on the CMS HQRP website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Key-Dates-for-Providers.html>. We used the analytic approach described above to determine reliability, validity, and reportability of the HIS-based Hospice Comprehensive Assessment Measure (NQF #3235). Reliability and validity testing found that the Hospice Comprehensive Assessment Measure had high reliability and validity. For more information about the reliability and validity of this measure, see the NQF Palliative and End-of-Life Care Off-Cycle Measure Review 2017 Publication available for

download here: https://www.qualityforum.org/Publications/2017/09/Palliative_and_End-of-Life_Care_Off-Cycle_Measure_Review_2017.aspx. Per the approach described above, we then conducted reportability analysis. Based on reportability analysis results, we determined this measure, calculated based on a 12-rolling month data selection period, to be eligible for public reporting with a minimum denominator size of 20 patient stays. A majority of hospices, using rolling 4 quarters of data, have at least 20 patient stays eligible for the calculation and public reporting of the Hospice Comprehensive Assessment Measure. We plan to begin public reporting of the Hospice Comprehensive Assessment Measure with a minimum denominator size of 20.

We also will begin public reporting of the HIS-based Hospice Visits when Death is Imminent Measure Pair in FY 2019. The same analytic approach described above will be applied to determine the reliability, validity, and reportability of the Hospice Visits when Death is Imminent Measure Pair. This measure pair assesses hospice staff visits to patients at the end of life. Draft specifications for the Hospice Visits when Death is Imminent measure pair are available on the CMS HQRP website here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>. With the finalization of our proposal to announce future intentions to publicly display hospice quality measures through sub-regulatory means, the exact timeline for public reporting of this measure pair will be announced through regular sub-regulatory channels once necessary analyses and measure specifications are finalized.

A summary of the comments received and our responses to those comments are below:

Comment: CMS received several supportive comments on the public display of the Hospice Comprehensive Assessment measure and the Hospice Visits when Death is Imminent Measure Pair in FY 2019. Most commenters focused on the Hospice Visits when Death is Imminent Measure Pair and were conditionally supportive of publicly reporting the measure pair. Those who were conditionally supportive asked that the measures be accompanied by text explaining the measures when publicly reported. CMS also received a comment opposing the public display of these measures in FY 2019, which is discussed below.

Response: We appreciate the commenters' support of publicly

displaying these two measures in FY 2019. We address commenters' specific concerns with respect to the public display of these measures below.

Comment: CMS received one comment that oppose public display of the Hospice Comprehensive Assessment Measure and Hospice Visits when Death is Imminent Measure Pair in FY 2019. This commenter stated that stakeholders have not had enough feedback data on their own individual measure performance to become comfortable with these measures and take steps to improve their measure performance prior to public reporting. The commenter suggested that CMS finalize policies to ensure hospices are able to review, analyze, and act on measure performance data before they are publicly reported.

Response: As statutorily required by section 1815(i)(5)(E) of the Act, we must "ensure that a hospice program has the opportunity to review data that is to be made public with respect to the hospice program prior to such data being made public." As such, we are not only committed, but statutorily obligated, to ensuring providers have the opportunity to review, analyze, and act on measure performance data before any measure performance data are publicly displayed. In accordance with the statutory requirements of the Act, we implemented the CASPER QM reports and the Provider Preview Reports as the manner by which hospices review their data prior to public reporting. The Preview Reports allow providers the opportunity to view their data exactly as it will be displayed on Hospice Compare, prior to any display. Should a provider find an error in the data to be displayed, the provider can follow the established process to request review of the data inaccuracy; should the inaccuracy be verified, we suppress that provider's data for that quarter. This process provides a safeguard for ensuring that the data reported on Compare are accurate. In addition, the CASPER QM reports allow providers to view their performance prior to Preview reports and prior to any public display, thus giving providers the opportunity to identify areas for improvement and implement performance improvement projects prior to the start of public reporting. For more information about these reports, see section III.F.6a of this final rule. The Hospice Comprehensive Assessment Measure was added to the CASPER QM report in February 2018, allowing providers ample time to assess their performance on the measure and implement performance improvement projects as appropriate. We will also post the Hospice Visits when Death is

Imminent Measure, which comprises a pair of measures, to the CASPER QM reports before public reporting of the measures so that providers can become familiar with them. Both measures, the Hospice Comprehensive Assessment Measure and Death is Imminent Measure, will also appear on providers' Preview Reports to ensure the scores to be displayed are accurate. Preview Reports will be released approximately 2 months prior to the Hospice Compare refresh in which measures are released. We will announce the timeline for reporting of these measures on the CASPER QM reports, Provider Preview Reports, and Hospice Compare once determined via the CMS HQRP website, 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.

Comment: Several commenters stated that the Hospice Visits when Death is Imminent Measure Pair, when publicly reported, may be confusing or misleading for consumers. For example, commenters shared that multiple factors, such as a patient and family's right to refuse visits, may account for lower performance on the measure pair. The commenters recommended that the measures be accompanied by text explaining this nuance when publicly reported.

Response: We are committed to ensuring that all publicly reported data is presented in an appropriate and meaningful manner to the public. As such, we work with our website development contractor to ensure that the Hospice Compare website is regularly tested for usability, readability, and navigation. We complete user access testing (UAT) with each refresh of the Hospice Compare website to ensure that the publicly posted data is accurate and clear. Furthermore, text on the Hospice Compare website complies with the Plain Language Act of 2010. In addition to complying with the Plain Language Act, we also take into account variations in health and general literacy, as well as solicit input from key stakeholders and technical experts in the development and presentation of publicly available data.

As we add more measures to the Hospice Compare website, including the Hospice Comprehensive Assessment Measure and Hospice Visits when Death is Imminent Measure Pair, we will, with consultation from key stakeholders, carefully craft explanatory language to ensure that consumers understand the measure's intent, relationship to quality,

and any necessary measure-specific nuance.

Comment: CMS received several general comments about public reporting of HIS-based measures. A few commenters were concerned that providers could easily change self-reported HIS data to avoid unfavorable scores being publicly reported on the Hospice Compare website. Another commenter stated that CMS should make more timely updates to quality data on Hospice Compare. This commenter stated that the lack of timely updates to the site may disincentive providers from implementing quality improvement efforts because it could take a year or longer to have updated data reflected on the Hospice Compare website. Another commenter stated that the measures currently on the Hospice Compare website were not clear as to if they are process measures, outcome measures, or measures of consumer feedback. Another commenter stated that consumers may misunderstand the current measures' intent and relationship to quality. Finally, CMS received one comment asking that CMS finalize policies so that measures will not be publicly posted based on the first year of performance data.

Response: Because no changes were proposed to validation of HIS data, frequency of updates to Hospice Compare, process for writing text for Hospice Compare, or data eligible for public reporting, comments received are outside the scope of the current rule.

We acknowledge the commenter's concern regarding the validity of self-reported HIS measures. Publicly reported QMs rely on the submission of valid and reliable data at the patient level. Our measure development contractor conducts ongoing testing and validation of the QM data to identify data irregularities and trends.

Furthermore, we are taking steps to ensure that publicly reported data are accurate. See section III.F.4b for more details on our finalized proposal to add a 4.5 month data correction deadline for public reporting for HIS data. This deadline will ensure that providers cannot correct data indefinitely and result in consumers receiving an inconsistent and potentially inaccurate view of hospice performance. By ensuring that data are reviewed and corrected prior to public reporting, data on Hospice Compare will be a consistent and accurate representation of hospice performance.

We are also committed to posting data on the Hospice Compare website that are as timely as possible. However, there will be an inevitable lag between data submission and public reporting on

Hospice Compare to allow for sufficient time for us to process the data, including completing any required testing and validation, and for hospices to review and correct any inaccuracies. This lag in public reporting is consistent across Quality Reporting Programs.

In reference to the text posted on Hospice Compare, we agree that it is important for consumers to be able to distinguish between process, outcome, and consumer feedback measures. Therefore, we have decided to separate the data into two sections on the Hospice Compare website: 'Family experience of care' and 'Quality of patient care'. Both sections have accompanying text explaining their data source. The website explains that the 'Family experience of care' data comes from a national survey that asks a family member or friend of a hospice patient about their hospice care experience. The 'Quality of patient care' section explains that this data is reported by hospices using the Hospice Item Set (HIS). Furthermore, we have included text explaining why these measures should be important to consumers.

In response to the commenter's recommendation of finalized policies so that measures will not be publicly posted based on the first year of performance data, we would like to remind readers that quality measures are added to Hospice Compare once they meet NQF readiness standards for public reporting, which is determined through the process outlined in section III.F.6a of this final rule. We analyze at least the first year of performance data to establish reliability and validity of the quality measures. If this data and the resultant quality measure scores are found to be reliable, valid, and scientifically acceptable from comprehensive analyses, we would publicly report this data if they meet NQF readiness standards.

Comment: A few commenters supported adding any new data to the Hospice Compare website. These commenters asked that no new data be added to Hospice Compare until after CMS correct any inaccurate data posted on the website. These commenters stated that the search function was returning inaccurate results and provider demographic data was incorrect on Hospice Compare. Moreover, the commenters stated that the data was updated too frequently, resulting in "week-to-week" changes and user confusion.

Response: Because no changes were proposed to the Hospice Compare search functionality or posted demographic data, comments received are outside the scope of the current rule.

However these comments made inaccurate statements that we want to correct. We are committed to posting accurate data to the Hospice Compare website, and goes to great lengths to ensure accuracy. Since the launch of the website, we would like to reassure the public of the accuracy of quality measure data on Hospice Compare. Quality measure data accuracy has never been questioned or an issue on Hospice Compare.

The one area we have addressed is improving the accuracy of the demographic data and search function. We have been transparent about addressing these issues with communications provided on both the Hospice Quality Reporting and the Hospice Compare websites. As explained in our communications, the demographic data reflects what hospices have provided. Updates to demographic data need to be made through the hospice provider's MAC. Information about updating hospice demographic data can be found in the How to Update Demographic Data document in the downloads section of the Public Reporting: Background and Announcements page on the CMS HQRP website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Background-and-Announcements.html>. We also recognize that updates to provider's demographic data (for example, address, telephone number, ownership) may take up to 6-months to appear on the Hospice Compare website. The process to update demographic data is independent of updating quality measure data or service areas and is controlled by the Medicare Administrative Contractor (MAC). It is important for hospices to review their HIS and CAHPS® Provider Preview Reports to verify that the demographic data is accurate. If inaccurate or outdated demographic data are included on the Preview Report or on Hospice Compare, hospice providers should follow guidance in the How to Update Demographic Data document in the downloads section of the Public Reporting: Background and Announcements page on the CMS HQRP website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Background-and-Announcements.html>.

As for the search function, we agree with providers that the accuracy of the search function is integral to the success of any Compare website. The search function, though, relates only to demographic results. The resulting

quality data provided about each hospice is accurate and has always been, including from the launch of Hospice Compare website. The current search function file, uploaded in May 2018, has addressed the accuracy and specificity of the Compare search function, as it is based on three sources of data: Claims, HIS, and geographic data. In response to comments about the accuracy of the Hospice Compare search function, we appreciate commenters' concerns but believe that, since the launch of Compare, the refinements we have made to the data underlying the search function have addressed the accuracy of the search function. We strive to continually improve and will continue to refine methods and data underlying the search function as appropriate. At this time, the search function works well because it is based on the geographic data using Core-Based Statistical Areas (CBSAs) that match to the paid claims and reflect the service areas of the Medicare-certified hospices. Since claims data lag, the CBSA's reflect the service areas at that time. Therefore to add more timely service area data, the unique zip codes from the HIS files are added. Consequently any new zip codes added to a service area likely come from HIS data and thereby update the search function during these quarterly refreshes. This is expected as part of the search function in the same way that updates to HIS and CAHPS quality data are expected quarterly on Hospice Compare. Therefore, in response to the commenter's concern about frequency of data updates on Compare and how that impacts the consistency of the search function, we would like to note that the file used to power the search function is updated quarterly, at the same time we update the quality measure data displayed on Hospice Compare. These quarterly updates to Hospice Compare are the regular refresh timeframes for this website so that Hospice Compare provides users with updated data from HIS and CAHPS® Hospice Surveys, which we believe stakeholders want the most recently available data. These quarterly refreshes also update the database of zip codes used to power the search function with new data collected from the HIS, providing a more comprehensive set of hospice service areas.

c. Updates to the Public Display of HIS Measures

As discussed previously, we strive to put patients first, ensuring they are empowered to make decisions about their own healthcare, along with their clinicians, using data-driven information that are increasingly

aligned with a parsimonious set of meaningful quality measures that drive quality improvement. We recognize that the HQRP represents a key component in bringing quality measurement, transparency, and improvement to the hospice care setting. To that end, we have begun analyzing our programs' measures in accordance with the Meaningful Measures framework to ensure high quality care that empowers patients to make decisions about their own healthcare, using consumable, data-driven information.

With this framework in mind, we evaluated our measure set and specifically the measure Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (NQF #3235) which we intend to publicly display on the Hospice Compare website in FY 2019. Through feedback received, we have learned that while the 7 original HIS measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617) that represent the individual care processes captured in this composite measure are important, the composite measure provides for consumers a more accessible measure for evaluating the quality of a hospice.

The composite measure is more illustrative than the individual, high performing measures based on analyses. The hospice performance scores on the 7 component measures that comprise the composite measure are high (a score of 90 percent or higher on most component measures); however, analyses also show that, on average, a much lower percentage of patient stays received all seven desirable care processes at admission. Thus, by assessing hospices' performance of a comprehensive assessment through an all-or-none calculation methodology, the composite measure sets a higher standard of care for hospices and reveals a larger performance gap. Meaning, the composite measure holds hospices to a higher standard by requiring them to perform all seven care processes for a given patient admission. The performance gap identified by the composite measure creates opportunities for quality improvement and may motivate providers to conduct a greater number of high priority care processes for as many patients as possible upon admission to hospice.

The table below shows the mean measure score across all hospices for Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment Measure at Admission and the 7 component measures that will no longer be routinely individually

displayed on Hospice Compare once the composite measure is displayed.

TABLE 11—MEAN MEASURE SCORE OF THE HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT MEASURE AT ADMISSION AND 7 ORIGINAL HIS COMPONENT MEASURES

Measure title	Measure score (percent)
Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (NQF #3235)	71.3
Component Measure: Treatment Preferences (NQF #1641)	98.8
Component Measure: Beliefs/Values (NQF #1647)	95.9
Component Measure: Pain Screening (NQF #1634)	93.2
Component Measure: Pain Assessment (NQF #1637)	72.5
Component Measure: Dyspnea Screening (NQF #1639)	98.5
Component Measure: Dyspnea Treatment (NQF #1638)	92.8
Component Measure: Bowl Regimen (NQF #1617)	97.5

Further, reporting of these 7 component measures alongside the composite measure may be redundant and may result in confusion and burden for users as they attempt to interpret data displayed on the Hospice Compare website. However, we also recognize that the component measures may be useful to some individuals using Hospice Compare. Therefore, while we will no longer directly display the 7 component measures as individual measures on Hospice Compare, once the composite measure is displayed, we will still provide the public the ability to view these component measures in a manner that avoids confusion on Hospice Compare. We plan to achieve this by reformatting the display of the component measures so that they are only viewable in an expandable/collapsible format under the composite measure itself, thus allowing users the opportunity to view the component measure scores that were used to calculate the main composite measure score.

This will change only the display of data on Hospice Compare for the HIS-based measure(s). This will not change any current HIS data collection procedures outlined in the FY 2018 Hospice final rule (82 FR 36663 through 36664). Providers will still collect all

HIS items in the current version of the HIS (HIS V2.00.0), including the 7 aforementioned component measures. Providers will continue to follow the coding guidelines and policies outlined in the HIS Manual V2.00, which can be found under the Downloads section of the HIS page of the HQRP website <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>. Therefore, this change to the display of data on Hospice Compare will not impact data collection. Additionally, because the composite measure is composed of the 7 aforementioned component measures, these component measures will still be reported on CASPER QM reports and HIS provider preview reports for providers' internal quality purposes.

We received multiple comments on this proposal to no longer directly display the 7 component measures as individual measures on Hospice Compare, once Hospice Comprehensive Assessment measure is displayed. A summary of the comments we received on this topic and our responses to those comments are below:

Comment: CMS received multiple comments that were supportive of no longer directly displaying the 7 component HIS measures as individual measures on Hospice Compare once the Hospice Comprehensive Assessment measure is publicly reported. Commenters noted that displaying the 7 component measures in an expandable/collapsible format under the Hospice Comprehensive Assessment measure is preferable for consumers. In addition to receiving comments indicating general support, commenters also raised several concerns about the proposed changes to display of HIS data on Compare.

Response: We appreciate commenters' support of no longer directly displaying the 7 component HIS measures as individual measures on Hospice Compare once the Hospice Comprehensive Assessment measure is publicly reported. We address commenters' specific concerns with respect to the public display of the Hospice Comprehensive Assessment measure and its composite of the 7 component original HIS measures below.

Comment: Many commenters stated that, since the Hospice Comprehensive Assessment measure is a composite of the 7 HIS measures, a low score for one of the 7 HIS measures could easily skew providers' scores on the Hospice Comprehensive Assessment measure. One commenter stated that this could be especially problematic for small hospice providers. Commenters stated that the

reformatted display of Hospice Compare would make it more difficult for consumers to find or even hide the scores for the 7 component measures hospices were performing well and that may be more easily interpretable to them in favor of directly displaying the one Hospice Comprehensive Assessment measure with less favorable performance.

Response: We agree with commenters that the 7 component HIS measures may be useful to some consumers of the site. Therefore, as stated in the proposed rule, we will not be removing the measures, nor will we obfuscate the display of these measures on Compare. We plan to display the 7 component HIS measures directly under the Hospice Comprehensive Assessment measure in an expandable/collapsible format. We will make it clear that the 7 component measures are available for those who would like more information about provider quality scores. Furthermore, as with the currently displayed HIS measures, we will include text explaining the Hospice Comprehensive Assessment measure and its relation to quality care.

Analyses indicate that the Hospice Comprehensive Assessment measure is more illustrative than the component, high performing measures and, on average, a much lower percentage of patient stays received all 7 desirable care processes at admission. Thus, by assessing hospices' performance of a comprehensive assessment through an all-or-none calculation methodology, the Hospice Comprehensive Assessment measure sets a higher standard of care for hospices and reveals a larger performance gap. This performance gap creates opportunities for quality improvement and may motivate providers to conduct a greater number of high priority care processes for as many patients as possible upon admission to hospice. Furthermore, discussions with key stakeholders indicate that, because of this performance gap, the Hospice Comprehensive Assessment measure is a more indicative measure for consumers when evaluating quality of care provided by a hospice. In summary, by directly displaying only this measure we will: (a) Provide consumers with one measure to easily compare providers on quality of care; and (b) incentivize hospices to conduct a greater number of care processes for as many patients as possible. We also recognize that the 7 component measures are useful to consumers and we are committed to making them easily accessible, while keeping the Hospice Compare site as user-friendly as possible.

As with the currently reported 7 HIS measures, the Hospice Comprehensive Assessment Measure will be reported with a minimum denominator size of 20 patient stays. This minimum denominator size ensures that quality measure scores are based on a large enough denominator to generate a statistically reliable score for public reporting. Therefore, hospices with small denominator sizes (<20 patient stays) for the Hospice Comprehensive Assessment Measure, which may be at higher risk of a skewed score, will not have scores for this measure reported on Hospice Compare.

Comment: Many commenters noted that many providers have high scores on the current seven HIS-based QMs and that the limited range of scores could make it difficult for consumers to differentiate between high- and low-quality providers. One commenter suggested eliminating the seven measures for this reason.

Response: We agree that many hospice providers are performing well on the seven HIS-based QMs. The overall distribution and variability of the scores of the seven HIS QMs that are currently publicly displayed initially indicate that most hospices are completing the important care processes for most hospice patients around hospice admission. However, there is still noticeable room for improvement. Analysis completed by RTI International shows that a low percentage of hospices have perfect scores for most measures and a small percentage of hospices have very low scores. Moreover, interviews with caregivers found that public display of these measures would be useful in avoiding low-performing providers. Additionally, publicly reporting these measures inform consumers of the important care processes that they should expect upon hospice admission. Last but not the least, the seven HIS QMs allow consumers to review the QMs associated with the individual care processes that they feel are particularly applicable to them.

Final Decision: After consideration of the comments, we are finalizing our proposal to no longer directly display the 7 component measures as individual measures on Hospice Compare, once the Hospice Comprehensive Assessment measure is displayed.

d. Display of Public Use File Data and/or Other Publicly Available CMS Data on the Hospice Compare Website

In the FY 2016 Hospice Wage Index final rule (80 FR 47199), we announced that we would make available hospice data in a public data set, the Medicare

Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (PUF), as part of our ongoing efforts to make healthcare more transparent, affordable, and accountable. Hospice data has been available at the provider-level in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF since 2016 and is located at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice.html>. The primary data source for the Hospice PUF is the CMS Chronic Condition Data Warehouse (CCW), a database with 100 percent of Medicare enrollment and fee-for-service adjudicated claims data.

These Hospice PUFs serve as a resource for the health care community by providing information on services provided to Medicare beneficiaries by hospice providers. The Hospice PUF contains information on utilization, payment (Medicare payment and standard payment), submitted charges, primary diagnoses, sites of service, and hospice beneficiary demographics organized by CMS Certification Number (6-digit provider identification number) and state. While these files are extensively downloaded by the public and especially researchers, currently the files are not in a format that would be considered user-friendly for many of the consumers who would look for hospice information to support provider selection.

As part of our ongoing efforts to make the Hospice Compare website more informative to our beneficiaries, loved ones, and their families, we proposed to post information from these PUF and/or other publicly available CMS data to the Hospice Compare website in a user-friendly way. We proposed to use information available in these public files to develop a new section of the Hospice Compare website that will provide additional information along with the HIS and CAHPS® quality measures and demographic information already displayed. Other Compare websites, such as the Nursing Home Compare and the End Stage Renal Disease Compare websites, have an information section similar to what we anticipate posting.

Information on the Hospice Compare website for each hospice includes data from the PUF and/or other publicly available CMS data displayed in a consumer-friendly format. This means that we may display the data as shown from the PUF or present the data after additional calculations. For example, the data could be averaged over multiple years, displayed as a

percentage rather than the raw number so it has meaning to end-users, or other calculations in a given year or over multiple years. Any calculation will be performed on data exclusively from the source file like the PUF or other publicly available CMS data. The data may be displayed with supporting narrative when needed to make the data more understandable.

Examples, provided for illustration of how CMS could use the PUF or other publicly available CMS data, include:

- Percent of days a hospice provided routine home care (RHC) to patients, averaged over multiple years,
- Percent of primary diagnosis of patients served by the hospice (cancer, dementia, circulatory/heart disease, stroke, respiratory disease) which would be a calculation of the total number of patients by diagnosis and dividing by the total number of patients that the hospice served, and
- Site of service (long term care or non-skilled nursing facility, skilled nursing facility, inpatient hospital) with a notation of yes, based on whether the hospice serves patients in that facility type.

While these types of information are not quality measures, they capture information that many consumers seek during the provider selection process and, therefore, will help them to make an informed decision. For example, information about conditions treated by the hospice could show a patient with dementia if a hospice specializes or is experienced in caring for patients with this condition. Additionally, if a patient has a specific need, like receiving hospice care in a nursing home, information from the PUF could help this patient or their loved ones determine if a provider in their service area has provided care in this setting. Analyses of the PUF data show variation between hospice providers in the data points outlined above, indicating that these data points could be meaningful to consumers in comparing services provided by hospices based on the factors most important to them. PUF data can serve as one more piece of information, along with quality of care metrics from the HIS and CAHPS® Hospice Survey, to help consumers effectively and efficiently compare hospice providers and make an informed decision about their care in a stressful time.

By averaging or trending data over multiple years, the data applies to hospices broadly regardless of size or location or other factors. We anticipate that over time and as appropriate, we may add other items from the PUF or other publicly available CMS data to the

Hospice Compare website through sub-regulatory processes and plan to inform the public through regular HQR communication strategies, such as Open Door Forums, Medicare Learning Network, Spotlight announcements and other opportunities.

We received multiple comments on this proposal to add data from the Hospice PUF to Hospice Compare. A summary of the comments we received and our responses to those comments are below:

Comment: A majority of commenters supported the plan to post information from the PUF and/or other publicly available CMS data on the Hospice Compare website. Commenters stated this information would “give users additional insight into the industry and the specific provider.” Of those that were supportive, some were conditionally supportive. Those commenters supported display of PUF data as long as the public is involved in decision-making as to which data points would be posted and how. Those who supported the proposal stated that posting of PUF data could lead to consumer confusion and unintended consequences.

Response: We thank commenters for their support of this plan to post information from the PUF and/or other publicly available CMS data on the Hospice Compare website. We address commenters’ specific concerns below.

Comment: In addition to the three data points outlined in the proposal, several commenters suggested CMS add other data points from the PUF to Hospice Compare. Commenters suggested data points such as hospice size and business model.

Response: We support these commenters’ suggestions. The purpose of adding information from the PUF or other publicly available CMS data is to provide additional useful information to consumers as they consider hospice. We will take these into consideration as we determine which data points will be added to Hospice Compare.

Comment: Many commenters stated that displaying data from the PUF would be misleading for consumers since consumers may misinterpret this data as quality data. For this reason, some commenters supported posting PUF data to Hospice Compare. To mitigate any potential consumer confusion, commenters suggested that CMS solicit input from stakeholders, through rulemaking or other stakeholder engagement activities, to guide decisions on (1) what type of information is displayed on Hospice Compare, (2) what kind of transformations or calculations are done

to the data before it is publicly posted, and (3) how the data that is to be displayed will be explained in a consumer-friendly manner. One commenter also suggested CMS mature the PUF data before use.

Response: We agree that it is important to clearly distinguish between PUF data, which is informational data and quality measure data posted to Hospice Compare. As such, we plan to display data from the PUF in a distinct section of the Hospice Compare website, separate from the sections containing HIS and CAHPS® quality data. This will be similar to the approach taken on other CMS Compare websites. We will also include text to explain the data displayed from the PUF and will make clear this data provides information about hospice characteristics and is not a reflection of the quality of care a hospice provides. As with other data and text currently on Hospice Compare, we will, with consultation from key stakeholders, carefully craft explanatory language to ensure that consumers understand the PUF data and how the data are meant for informational purposes only.

We are committed to soliciting input from providers, key stakeholders, and the public when considering any refinements to Hospice Compare, including addition of PUF and/or other publicly available CMS data. As discussed in our response in section III.F.6a, the annual rulemaking cycle is not the only method by which this information can be communicated to the public and feedback can be solicited. Sub-regulatory channels can be equally or more effective at communicating and collaborating with the public since we can communicate more frequently through sub-regulatory means like Open Door Forums, Special Open Door Forums, and Medicare Learning Network, HQRPs Spotlight Page and its other web pages.

In reference to the comment suggesting “maturing” of PUF data before public reporting, we would like to clarify that PUF data is based on 100 percent fee-for-service final action claims. Thereby, the PUF reports out the hospices’ data from their paid claims using data files that were produced after 24 months of maturity. Therefore, stakeholders have confidence in this data that will be used on Hospice Compare. We would also note that the PUF data are currently reported on our website for the public and that this data will be reported in a more user-friendly format to improve usability by consumers. For more information about the PUF and methodology used to calculate the data, see the Medicare

Hospice Utilization & Payment Public Use File: A Methodological Overview here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Downloads/Hospice_Methodology.pdf.

Comment: A few commenters shared that the display of PUF data on Hospice Compare could lead to unintended consequences and, therefore, were unsupportive of displaying this data. Specifically, commenters shared that posting data about primary diagnoses served could lead consumers to falsely assume a hospice does not serve a particular diagnosis group, and that this would disproportionately affect small hospices.

Response: We agree that it is important to prevent unintended consequences of publicly posted data. To mitigate concerns, we plan to (1) average data over multiple years and (2) include text explaining the purpose of these data points and how consumers can use them. By averaging data over multiple years, changes in case mix from year-to-year will be accounted for. Moreover, data for small providers (≤ 10 hospice beneficiaries in a calendar year) or data points with ≤ 10 beneficiaries (that is, if a provider had ≤ 10 beneficiaries with a primary diagnosis of, for example, cancer) are suppressed in the PUF and cannot be displayed on Hospice Compare. We will make clear that information from the PUF is one more resource along with, but separate from, the quality of care data to help consumers make a more informed choice of hospice provider.

Final Decision: After consideration of the comments, we are finalizing our proposal to display data from the Hospice PUF on Hospice Compare.

Comment: CMS received several comments related to the Hospice Evaluation & Assessment Reporting Tool (HEART). Commenters highlighted the importance of developing a tool that reflects the holistic nature of hospice and expressed curiosity related to the timeline for HEART implementation and next steps for HEART development. Additionally, commenters emphasized the importance of using widespread processes to gather provider input related to HEART and ongoing education and support for future HEART implementation. Finally, commenters requested that HEART pilot test findings be broadly disseminated and explored, and that public comment be solicited through traditional rulemaking, prior to industry-wide implementation.

Response: Because no changes were proposed to the potential new hospice

data collection mechanism that is preliminarily being called the HEART, comments received are outside the scope of the current rule. We addressed these issues in the FY 2018 Hospice Wage Index final rule (82 FR 36638), and we refer the reader to that detailed discussion and the HQRPs web page on HEART at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html>.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-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.

We are solicited public comment on each of these issues for the following sections of this document that contain information collection requirements.

A. ICRs Regarding 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

We received no comments on the ICRs Regarding Hospice Item Set.

In section III.F of this rule, we are reformatting the 7 original HIS measures for purposes of public reporting display on Hospice Compare. This will not change any current HIS data collection procedures outlined in the FY 2018 Hospice final rule (82 FR 36663 through 36664). The HIS V2.00.0 was approved by the OMB on April 17, 2017 under OMB control number 0938–1153 (CMS–10390) for 1 year. The information collection request (ICR) is currently pending OMB approval for 3 years.

B. ICRs Regarding CAHPS® Hospice Survey

National Implementation of the Hospice Experience of Care Survey (CAHPs Hospice Survey) data measures (82 FR 36672) would not impose any new or revised reporting, recordkeeping, or third-party disclosure requirements and therefore, does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). The information collection requirements and burden have been approved by OMB through December 31, 2020 under OMB control number 0938–1257 (CMS–10537).

C. Submission of PRA-Related Comments

We have submitted a copy of this final rule to OMB for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB.

V. Regulatory Impact Analysis

A. Statement of Need

This final 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 final rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2019 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. In addition, the payment rate updates may

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). Lastly, section 3004 of the PPACA 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 rule will result in an increase of \$340 million in payments to hospices, resulting from the hospice payment update percentage of 1.8 percent. The impact analysis of this rule represents the projected effects of the changes in hospice payments from FY 2018 to FY 2019. Using the most recent data available at the time of rulemaking, in this case FY 2017 hospice claims data, we apply the current FY 2018 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 2018 payments. Then, using the same FY 2017 data, we apply the FY 2019 wage index and labor-related share values to simulate FY 2019 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 Regulatory Flexibility Act (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 greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The effect of the FY 2018 hospice payment update percentage results in an overall increase in estimated hospice payments of 1.8 percent, or \$340 million. Therefore, the

Secretary has determined that this rule will not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security 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 rule will only affect hospices. Therefore, the Secretary has determined that this rule will 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. The 2018 UMRA threshold is \$150 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of \$150 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 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 final 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 the published proposed rule will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this final rule. It is possible that not all commenters reviewed the proposed 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 comments received on the proposed rule would be a fair estimate of the number of reviewers of this final rule.

Using the wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is \$107.38 per hour, including overhead and fringe benefits (https://www.bls.gov/oes/current/oes_nat.htm). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 1 hour for the staff to review half of this rule which consists of approximately 30,000 words. For each hospice that reviews the rule, the estimated cost is \$107.38 (1 hour × \$107.38). Therefore, we estimate that the total cost of reviewing this regulation is \$9,664.20 (\$107.38 × 90 reviewers).

D. Detailed Economic Analysis

The FY 2019 hospice payment impacts appear in Table 12. We tabulate the resulting payments according to the

classifications in Table 12 (for example, facility type, geographic region, facility ownership), and compare the difference between current and future 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 FY 2019 hospice wage index. The aggregate impact of this change is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2019 hospice wage index.

The fourth column shows the effect of the hospice payment update percentage for FY 2019. The 1.8 percent hospice payment update percentage is based on the 2.9 percent inpatient hospital market basket update, reduced by a 0.8 percentage point productivity adjustment and by a 0.3 percentage point adjustment as required by statute, and is constant for all providers.

The fifth column shows the effect of all the changes on FY 2019 hospice payments. It is projected that aggregate payments would increase by 1.8 percent, assuming hospices do not change their service and billing practices.

As illustrated in Table 12, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 12—IMPACT TO HOSPICES FOR FY 2019

	Number of providers	Updated wage data (%)	FY 2019 hospice payment update (%)	FY 2019 total change (%)
All Hospices	4,440	0.0	1.8	1.8
Urban Hospices	3,550	0.0	1.8	1.8
Rural Hospices	890	0.1	1.8	1.9
Urban Hospices—New England	127	0.0	1.8	1.8
Urban Hospices—Middle Atlantic	250	0.0	1.8	1.8
Urban Hospices—South Atlantic	443	−0.1	1.8	1.7
Urban Hospices—East North Central	399	−0.1	1.8	1.7
Urban Hospices—East South Central	149	0.0	1.8	1.8
Urban Hospices—West North Central	242	0.2	1.8	2.0
Urban Hospices—West South Central	695	0.4	1.8	2.2
Urban Hospices—Mountain	359	−0.3	1.8	1.5
Urban Hospices—Pacific	845	0.1	1.8	1.9
Urban Hospices—Outlying	41	0.4	1.8	2.2
Rural Hospices—New England	27	1.6	1.8	3.4
Rural Hospices—Middle Atlantic	35	0.0	1.8	1.8
Rural Hospices—South Atlantic	108	0.0	1.8	1.8

TABLE 12—IMPACT TO HOSPICES FOR FY 2019—Continued

	Number of providers	Updated wage data (%)	FY 2019 hospice payment update (%)	FY 2019 total change (%)
Rural Hospices—East North Central	138	-0.1	1.8	1.7
Rural Hospices—East South Central	111	0.0	1.8	1.8
Rural Hospices—West North Central	168	0.3	1.8	2.1
Rural Hospices—West South Central	168	0.1	1.8	1.9
Rural Hospices—Mountain	93	-0.4	1.8	1.4
Rural Hospices—Pacific	42	0.1	1.8	1.9
Rural Hospices—Outlying	6	-0.3	1.8	1.5
0–3,499 RHC Days (Small)	999	0.2	1.8	2.0
3,500–19,999 RHC Days (Medium)	2,044	0.1	1.8	1.9
20,000+ RHC Days (Large)	1,397	0.0	1.8	1.8
Non-Profit Ownership	1,028	0.0	1.8	1.8
For Profit Ownership	2,858	0.0	1.8	1.8
Government Ownership	141	0.2	1.8	2.0
Other Ownership	413	-0.1	1.8	1.7
Freestanding Facility Type	3,638	0.0	1.8	1.8
HHA/Facility-Based Facility Type	802	-0.1	1.8	1.7

Source: FY 2017 hospice claims from the Chronic Conditions Data Warehouse (CCW) Research Identifiable Files (RIFs) as of May 29, 2018.

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. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 13, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 13 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this final rule. This estimate is based on the data for 4,440 hospices in our impact analysis file, which was constructed using FY 2017 claims available in May 2018. All expenditures are classified as transfers to hospices.

TABLE 13—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM FY 2018 TO FY 2019

Category	Transfers
Annualized Monetized Transfers.	\$340 million *
From Whom to Whom?.	Federal Government to Medicare Hospices.

* The net increase of \$340 million in transfer payments is a result of the 1.8 percent hospice payment update compared to payments in FY 2018.

F. Regulatory Reform Analysis Under E.O. 13771

Executive Order 13771, entitled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017 (82 FR 9339, February 3, 2017) and requires that the costs associated with significant new regulations “shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.” It has been determined that this rule is an action that primarily results in transfers and does not impose more than *de minimis* costs as described above and thus is not a regulatory or deregulatory action for the purposes of Executive Order 13771.

G. Conclusion

We estimate that aggregate payments to hospices in FY 2019 will increase by \$340 million, or 1.8 percent, compared to payments in FY 2018. We estimate that in FY 2019, hospices in urban and rural areas will experience, on average, 1.8 percent and 1.9 percent increases, respectively, in estimated payments compared to FY 2018. Hospices providing services in the urban West South Central and Outlying regions and the rural New England region would experience the largest estimated increases in payments of 2.2 percent and 3.4 percent, respectively. Hospices serving patients in rural areas in the Mountain region would experience, on

average, the lowest estimated increase of 1.4 percent in FY 2019 payments.

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

List of Subjects in 42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 418—HOSPICE CARE

- 1. The authority citation for part 418 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

- 2. Section 418.3 is amended—
 - a. In the definition of “Attending physician”, by revising paragraph (1); and
 - b. By revising the definition of “Cap period”.

The revisions read as follows:

§ 418.3 Definitions.

* * * * *

Attending physician * * *

(1)(i) Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or

(ii) Nurse practitioner who meets the training, education, and experience requirements as described in § 410.75(b) of this chapter; or

(iii) Physician assistant who meets the requirements of § 410.74(c) of this chapter.

* * * * *

Cap period means the twelve-month period ending September 30 used in the application of the cap on overall hospice reimbursement specified in § 418.309.

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■ 3. Section 418.304 is amended by revising the section heading and adding paragraph (f) to read as follows:

§ 418.304 Payment for physician, and nurse practitioner, and physician assistant services.

* * * * *

(f)(1) Effective January 1, 2019, Medicare pays for attending physician services provided by physician assistants to Medicare beneficiaries who have elected the hospice benefit and who have selected a physician assistant as their attending physician. This

applies to physician assistants without regard to whether they are hospice employees.

(2) The employer or a contractor of a physician assistant must bill and receive payment for physician assistant services only if the—

(i) Physician assistant is the beneficiary's attending physician as defined in § 418.3;

(ii) Services are medically reasonable and necessary;

(iii) Services are performed by a physician in the absence of the physician assistant and, the physician assistant services are furnished under the general supervision of a physician; and

(iv) Services are not related to the certification of terminal illness specified in § 418.22.

(3) The payment amount for physician assistant services when serving as the attending physician for hospice patients is 85 percent of what a physician is paid under the Medicare physician fee schedule.

■ 4. Section 418.309 is amended by revising paragraph (b)(1) to read as follows:

§ 418.309 Hospice aggregate cap.

* * * * *

(b) * * *

(1) In the case in which a beneficiary received care from only one hospice, the hospice includes in its number of Medicare beneficiaries those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap, and who have filed an election to receive hospice care in accordance with § 418.24 during the cap period as defined in § 418.3, using the best data available at the time of the calculation.

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Dated: July 26, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 26, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

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