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Medicare Program; FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS-1652-P]

RIN 0938-AS79

Medicare Program; FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2017. In addition, this rule proposes changes to the hospice quality reporting program, including proposing new quality measures. The proposed rule also solicits feedback on an enhanced data collection instrument and describes plans to publicly display quality measures and other hospice data beginning in the middle of 2017. Finally, this proposed rule includes information regarding the Medicare Care Choices Model (MCCM).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 20, 2016.

ADDRESSES: In commenting, please refer to file code CMS-1652-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1652-P, P.O. Box 8010, Baltimore, MD 21244-8010.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1652-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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

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

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT: Debra Dean-Whittaker, (410) 786-0848 for questions regarding the CAHPS® Hospice Survey.

Michelle Brazil, (410) 786-1648 for questions regarding the hospice quality reporting program.

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

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

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

www.regulations.gov. Follow the search instructions on that Web site to view public comments.

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

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Acronyms

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

APU Annual Payment Update
 ASPE Assistant Secretary of Planning and Evaluation
 BBA Balanced Budget Act of 1997
 BETOS Berenson-Eggers Types of Service
 BIPA Benefits Improvement and Protection Act of 2000

BNAF Budget Neutrality Adjustment Factor
 BLS Bureau of Labor Statistics
 CAHPS® Consumer Assessment of Healthcare Providers and Systems
 CBSA Core-Based Statistical Area
 CCN CMS Certification Number
 CCW Chronic Conditions Data Warehouse
 CFR Code of Federal Regulations
 CHC Continuous Home Care
 CHF Congestive Heart Failure
 CMMI Center for Medicare & Medicaid Innovation
 CMS Centers for Medicare & Medicaid Services
 COPD Chronic Obstructive Pulmonary Disease
 CoPs Conditions of Participation
 CPI Center for Program Integrity
 CPI-U Consumer Price Index—Urban Consumers
 CR Change Request
 CVA Cerebral Vascular Accident
 CWF Common Working File
 CY Calendar Year
 DME Durable Medical Equipment
 DRG Diagnostic Related Group
 ER Emergency Room
 FEHC Family Evaluation of Hospice Care
 FR Federal Register
 FY Fiscal Year
 GAO Government Accountability Office
 GIP General Inpatient Care
 HCFA Healthcare Financing Administration
 HHS Health and Human Services
 HIPAA Health Insurance Portability and Accountability Act
 HIS Hospice Item Set
 HQRP Hospice Quality Reporting Program
 IACS Individuals Authorized Access to CMS Computer Services
 ICD-9-CM International Classification of Diseases, Ninth Revision, Clinical Modification
 ICD-10-CM International Classification of Diseases, Tenth Revision, Clinical Modification
 ICR Information Collection Requirement
 IDG Interdisciplinary Group
 IMPACT Act Improving Medicare Post-Acute Care Transformation Act of 2014
 IOM Institute of Medicine
 IPPS Inpatient Prospective Payment System
 IRC Inpatient Respite Care
 LCD Local Coverage Determination
 MAC Medicare Administrative Contractor
 MAP Measure Applications Partnership
 MCCM Medicare Care Choices Model
 MedPAC Medicare Payment Advisory Commission
 MFP Multifactor Productivity
 MSA Metropolitan Statistical Area
 MSS Medical Social Services
 NHPCO National Hospice and Palliative Care Organization
 NF Long Term Care Nursing Facility
 NOE Notice of Election
 NOTR Notice of Termination/Revocation
 NP Nurse Practitioner
 NPI National Provider Identifier
 NQF National Quality Forum
 OIG Office of the Inspector General
 OACT Office of the Actuary
 OMB Office of Management and Budget
 PEPPER Program for Evaluating Payment Patterns Electronic Report
 PRRB Provider Reimbursement Review Board

PS&R Provider Statistical and Reimbursement Report
 Pub. L Public Law
 QAPI Quality Assessment and Performance Improvement
 RHC Routine Home Care
 RN Registered Nurse
 SBA Small Business Administration
 SEC Securities and Exchange Commission
 SIA Service Intensity Add-on
 SNF Skilled Nursing Facility
 TEFRA Tax Equity and Fiscal Responsibility Act of 1982
 TEP Technical Expert Panel
 UHDDS Uniform Hospital Discharge Data Set
 U.S.C. United States Code

I. Executive Summary for this Proposed Rule

A. Purpose

This rule proposes updates to the hospice payment rates for fiscal year (FY) 2017, as required under section 1814(i) of the Social Security Act (the Act). This rule also proposes new quality measures and provides an update on the hospice quality reporting program (HQRP) consistent with the requirements of section 1814(i)(5) of the Act, as added by section 3004(c) of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act (Pub. L. 111–152) (collectively, the Affordable Care Act). In accordance with section 1814(i)(5)(A) of the Act, starting in FY 2014, hospices that have failed to meet quality reporting requirements receive a 2 percentage point reduction to their payments. Finally, this proposed rule shares information on the Medicare Care Choices Model developed in accordance with the authorization under section 1115A of the Act for the Center for Medicare and Medicaid Innovation (CMMI) to test innovative payment and service models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program (CHIP) expenditures while maintaining or improving the quality of care.

B. Summary of the Major Provisions

Section III.A of this proposed rule describes current trends in hospice utilization and provider behavior, as well as our efforts for monitoring potential impacts related to the hospice reform policies finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142). In section III.B.1 of this proposed rule, we propose to update the hospice wage index with updated wage data and to make the application of the updated wage data budget neutral for all four levels of hospice care. In section III.B.2 we discuss the FY 2017 hospice

payment update percentage of 2.0 percent. Sections III.B.3 and III.B.4 update the hospice payment rates and hospice cap amount for FY 2017 by the hospice payment update percentage discussed in section III.B.2.

In section III.C of this proposed rule, we discuss updates to HQRP, including the proposal of two new quality measures as well as of the possibility of utilizing a new assessment instrument to collect quality data. As part of the HQRP, the new proposed measures would be: (1) Hospice Visits When Death is Imminent, assessing hospice staff visits to patients and caregivers in the last week of life; and (2) Hospice and Palliative Care Composite Process Measure, assessing the percentage of hospice patients who received care processes consistent with existing guidelines. In section III.C we will also discuss the potential enhancement of the current Hospice Item Set (HIS) data collection instrument to be more in line with other post-acute care settings. This new data collection instrument would be a comprehensive patient assessment instrument, rather than the current chart abstraction tool. Additionally, in this section we discuss our plans for sharing HQRP data publicly during Calendar Year (CY) 2016 as well as plans to provide public reporting via a Compare Site in CY 2017.

Finally, in section III.D, we are providing information regarding the Medicare Care Choices Model (MCCM). This model offers a new option for Medicare and dual eligible beneficiaries with certain advanced diseases who meet the model's other eligibility criteria to receive hospice-like support services from MCCM participating hospices while receiving care from other Medicare providers for their terminal illness. This model is designed to: (1) Increase access to supportive care services provided by hospice; (2) improve quality of life and patient/family/caregiver satisfaction; and (3) inform new payment systems for the Medicare and Medicaid programs.

C. Summary of Impacts

TABLE 1—IMPACT SUMMARY

Provision description	Transfers
FY 2017 Hospice Wage Index and Payment Rate Update.	The overall economic impact of this proposed rule is estimated to be \$330 million in increased payments to hospices during FY 2017.

II. Background

A. Hospice Care

Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through use of a broad spectrum 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-centered care for those who are terminally ill. It is a comprehensive, holistic approach to treatment that recognizes that the impending death of an individual necessitates a transition from curative to palliative care.

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. *See also* Hospice Conditions of Participation final rule (73 FR 32088 June 5, 2008). The goal of palliative care in hospice is to improve the quality of life of beneficiaries, and their families, facing the issues associated with a life-threatening illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other issues that may arise. This is achieved by the hospice interdisciplinary team working with the beneficiary and family to develop a comprehensive care plan focused on coordinating care services, reducing unnecessary diagnostics or ineffective therapies, and offering ongoing conversations with individuals and their families about changes in their condition. The beneficiary’s comprehensive care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

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

While the goal of hospice care is to allow the beneficiary to remain in his or her home environment, circumstances during the end-of-life may necessitate short-term inpatient admission to a hospital, skilled nursing facility (SNF), or hospice facility for treatment necessary for pain control or acute or chronic symptom management that cannot be managed in any other setting. These acute hospice care services are to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home environment. Limited, short-term, intermittent, inpatient respite services are also available to the family/caregiver of the hospice patient to relieve the family or other caregivers. Additionally, an individual can receive continuous home care during a period of crisis in which an individual requires primarily continuous nursing care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. Continuous home care may be covered on a continuous basis 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, and to provide language access for such persons who are limited in English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at <http://www.hhs.gov/ocr/civilrights>.

B. History of the Medicare Hospice Benefit

Before the creation of the Medicare hospice benefit, hospice programs were originally operated by volunteers who cared for the dying. During the early development stages of the Medicare hospice benefit, hospice advocates were clear that they wanted a Medicare benefit that provided all-inclusive care for terminally-ill individuals, provided pain relief and symptom management, and offered the opportunity to die with dignity in the comfort of one's home rather than in an institutional setting.¹ As stated in the August 22, 1983 proposed rule entitled "Medicare Program; Hospice Care" (48 FR 38146), "the hospice experience in the United States has placed emphasis on home care. It offers physician services, specialized nursing services, and other forms of care in the home to enable the terminally ill individual to remain at home in the company of family and friends as long as possible." The concept of a beneficiary "electing" the hospice benefit and being certified as terminally ill were two key components of the legislation responsible for the creation of the Medicare Hospice Benefit (section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), (Pub. L. 97-248)). Section 122 of TEFRA created the Medicare Hospice benefit, which was implemented on November 1, 1983. Under sections 1812(d) and 1861(dd) of the Act, we provide coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a Medicare-certified hospice. Our regulations at § 418.54(c) stipulate that the comprehensive hospice assessment must identify the beneficiary's physical, psychosocial, emotional, and spiritual

needs related to the terminal illness and related conditions, and address those needs in order to promote the beneficiary's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors: the nature and condition causing admission (including the presence or lack of objective data and subjective complaints); complications and risk factors that affect care planning; functional status; imminence of death; and severity of symptoms (§ 418.54(c)). The Medicare hospice benefit requires the hospice to cover all reasonable and necessary palliative care related to the terminal prognosis, as described in the beneficiary's plan of care. The December 16, 1983 Hospice final rule (48 FR 56008) requires hospices to cover care for interventions to manage pain and symptoms. Additionally, the hospice Conditions of Participation (CoPs) at § 418.56(c) require that the hospice must provide all reasonable and necessary services for the palliation and management of the terminal illness, related conditions, and interventions to manage pain and symptoms. Therapy and interventions must be assessed and managed in terms of providing palliation and comfort without undue symptom burden for the hospice patient or family.² In the December 16, 1983 Hospice final rule (48 FR 56010), regarding what is related versus unrelated to the terminal illness, we stated: ". . . we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case by case basis. It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients." Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis, all conditions are considered to be related to the terminal prognosis and the responsibility of the hospice to address and treat.

As stated in the December 16, 1983 Hospice final rule, the fundamental premise upon which the hospice benefit was designed was the "revocation" of traditional curative care and the "election" of hospice care for end-of-life symptom management and maximization of quality of life (48 FR 56008). After electing hospice care, the beneficiary typically returns to the home from an institutionalized setting or remains in the home, to be surrounded by family and friends, and

to prepare emotionally and spiritually, if requested, for death while receiving expert symptom management and other supportive services. Election of hospice care also requires waiving the right to Medicare payment for curative treatment for the terminal prognosis, and instead receiving palliative care to manage pain or other symptoms.

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

C. Services Covered by the Medicare Hospice Benefit

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

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before care is provided by, or under arrangements made by, that hospice program and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and

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

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

an interdisciplinary group (described in section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act). Upon the implementation of the hospice benefit, the Congress expected hospices to continue to use volunteer services, though these services are not reimbursed by Medicare (see Section 1861(dd)(2)(E) of the Act and 48 FR 38149). As stated in the August 22, 1983 Hospice proposed rule, the hospice interdisciplinary group should comprise paid hospice employees as well as hospice volunteers (48 FR 38149). This expectation supports the hospice philosophy of holistic, comprehensive, compassionate, end-of-life care.

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

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

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

D. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the

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

1. Omnibus Budget Reconciliation Act of 1989

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

2. Balanced Budget Act of 1997

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

3. FY 1998 Hospice Wage Index Final Rule

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

4. FY 2010 Hospice Wage Index Final Rule

Inpatient hospital pre-floor and pre-reclassified wage index values, as described in the August 8, 1997 Hospice Wage Index final rule, are subject to either a budget neutrality adjustment or application of the wage index floor. Wage index values of 0.8 or greater are adjusted by the BNAF. Starting in FY 2010, a 7-year phase-out of the BNAF began (FY 2010 Hospice Wage Index final rule, (74 FR 39384, August 6, 2009)), with a 10 percent reduction in FY 2010, an additional 15 percent reduction for a total of 25 percent in FY 2011, an additional 15 percent reduction for a total 40 percent reduction in FY 2012, an additional 15 percent reduction for a total of 55 percent in FY 2013, and an additional 15 percent reduction for a total 70 percent reduction in FY 2014. The phase-out continued with an additional 15 percent reduction for a total reduction of 85 percent in FY 2015, an additional, and final, 15 percent reduction for complete elimination in FY 2016. We note that the BNAF was an

adjustment which increased the hospice wage index value. Therefore, the BNAF phase-out reduced the amount of the BNAF increase applied to the hospice wage index value. It was not a reduction in the hospice wage index value itself or in the hospice payment rates.

5. The Affordable Care Act

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

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

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the Affordable Care Act, requires, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary's hospice care prior to the 180th-day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, we finalized in the CY 2011 Home Health Prospective Payment System final rule (75 FR 70435) that the 180th-day recertification and subsequent recertifications would correspond to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the Affordable Care Act, authorizes the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the Affordable Care Act could capture accurate resource utilization, which could be

collected on claims, cost reports, and possibly other mechanisms, as the Secretary determined to be appropriate. The data collected could be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, we were required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

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

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

When electing hospice, a beneficiary waives Medicare coverage for any care

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

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

Hospice providers are required to begin using a Hospice Experience of

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

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

8. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113–185) (IMPACT Act) became law on October 6, 2014. Section 3(a) of the IMPACT Act mandated that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025. In addition, section 3(c) of the IMPACT Act requires medical review of hospice cases involving beneficiaries receiving more than 180 days care in select hospices that show a preponderance of such patients; section 3(d) of the IMPACT Act contains a new provision mandating that the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025 be updated by the hospice payment update rather than using the consumer price index for urban consumers (CPI-U) for medical care expenditures.

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

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

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

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

E. Trends in Medicare Hospice Utilization

Since the implementation of the hospice benefit in 1983, and especially within the last decade, there has been substantial growth in hospice benefit utilization. The number of Medicare

beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to nearly 1.4 million in FY 2015. Similarly, Medicare hospice expenditures have risen from \$2.8 billion in FY 2000 to an estimated \$15.5 billion in FY 2015. Our Office of the Actuary (OACT) projects that hospice expenditures are expected to continue to increase, by approximately 7 percent annually, reflecting an increase in the number of Medicare beneficiaries, more beneficiary awareness of the Medicare Hospice Benefit for end-of-life care, and a growing preference for care provided in home and community-based settings.

There have also been changes in the diagnosis patterns among Medicare hospice enrollees. Specifically, as described in Table 2, there have been notable increases between 2002 and 2015 in neurologically-based diagnoses, including various dementia and Alzheimer’s diagnoses. Additionally, there had been significant increases in the use of non-specific, symptom-classified diagnoses, such as “debility” and “adult failure to thrive.” In FY 2013, “debility” and “adult failure to thrive” were the first and sixth most common hospice diagnoses, respectively, accounting for approximately 14 percent of all diagnoses. Effective October 1, 2014, hospice claims are returned to the provider if “debility” and “adult failure to thrive” are coded as the principal hospice diagnosis as well as other ICD–9–CM (and as of October 1, 2015, ICD–10–CM) codes that are not permissible as principal diagnosis codes per ICD–9–CM (or ICD–10–CM) coding guidelines. In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452), we reminded the hospice industry that this policy would go into effect and claims would start to be returned to the provider effective October 1, 2014. As a result of this, there has been a shift in coding patterns on hospice claims. For FY 2015, the most common hospice principal diagnoses were Alzheimer’s disease, Congestive Heart Failure, Lung Cancer, Chronic Airway Obstruction and Senile Dementia which constituted approximately 35 percent of all claims-reported principal diagnosis codes reported in FY 2015 (see Table 2).

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2015

Rank	ICD–9/reported principal diagnosis	Count	Percentage
Year: FY 2002			
1	162.9 Lung Cancer	73,769	11
2	428.0 Congestive Heart Failure	45,951	7
3	799.3 Debility Unspecified	36,999	6

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2015—Continued

Rank	ICD-9/reported principal diagnosis	Count	Percentage
4	496 COPD	35,197	5
5	331.0 Alzheimer's Disease	28,787	4
6	436 CVA/Stroke	26,897	4
7	185 Prostate Cancer	20,262	3
8	783.7 Adult Failure To Thrive	18,304	3
9	174.9 Breast Cancer	17,812	3
10	290.0 Senile Dementia, Uncomp	16,999	3
11	153.0 Colon Cancer	16,379	2
12	157.9 Pancreatic Cancer	15,427	2
13	294.8 Organic Brain Synd Nec	10,394	2
14	429.9 Heart Disease Unspecified	10,332	2
15	154.0 Rectosigmoid Colon Cancer	8,956	1
16	332.0 Parkinson's Disease	8,865	1
17	586 Renal Failure Unspecified	8,764	1
18	585 Chronic Renal Failure (End 2005)	8,599	1
19	183.0 Ovarian Cancer	7,432	1
20	188.9 Bladder Cancer	6,916	1

Year: FY 2007

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

Year: FY 2013

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

Year: FY 2015

1	331.0 Alzheimer's disease	195,469	13
2	428.0 Congestive heart failure, unspecified	114,240	8
3	162.9 Lung Cancer	87,661	6
4	496 COPD	80,081	5
5	331.2 Senile degeneration of brain	46,610	3
6	332.0 Parkinson's Disease	34,734	2

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2015—Continued

Rank	ICD-9/reported principal diagnosis	Count	Percentage
7	429.9 Heart disease, unspecified	31,695	2
8	436 CVA/Stroke	28,985	2
9	437.0 Cerebral atherosclerosis	26,765	2
10	174.9 Breast Cancer	23,742	2
11	153.9 Colon Cancer	23,677	2
12	185 Prostate Cancer	23,061	2
13	157.9 Pancreatic Cancer	22,906	2
14	585.6 End stage renal disease	22,763	2
15	491.21 Obstructive chronic bronchitis with (acute) exacerbation	21,283	1
16	518.81 Acute respiratory failure	19,965	1
17	429.2 Cardiovascular disease, unspecified	16,843	1
18	434.91 Cerebral artery occlusion, unspecified with cerebral infarction	15,642	1
19	414.00 Coronary atherosclerosis of unspecified type of vessel	15,566	1
20	188.9 Bladder Cancer	11,517	1

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

Source: FY 2002 and 2007 hospice claims data from the Chronic Conditions Data Warehouse (CCW), accessed on February 14 and February 20, 2013. FY 2013 hospice claims data from the CCW, accessed on June 26, 2014, and preliminary FY 2015 hospice claims data from the CCW, accessed on January 25, 2016.

While there has been a shift in the reporting of the principal diagnosis as a result of diagnosis clarifications, a significant proportion of hospice claims (49 percent) in FY 2014 only reported a single principal diagnosis, which may not fully explain the characteristics of Medicare beneficiaries who are approaching the end of life. To address this pattern of single diagnosis reporting, the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50498) reiterated ICD-9-CM coding guidelines for the reporting of the principal and additional diagnoses on the hospice claim. We reminded providers to report all diagnoses on the hospice claim for the terminal illness and related conditions, including those that affect the care and clinical management for the beneficiary. Additionally, in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47201), we provided further clarification regarding diagnosis reporting on hospice claims. We clarified that hospices will report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, effective October 1, 2015. Preliminary analysis of FY 2015 hospice claims show that only 37 percent of hospice claims include a single, principal diagnosis, with 63 percent submitting at least two diagnoses and 46 percent including at least three.³

F. Use of Health Information Technology

HHS believes that the use of certified health IT by hospices can help providers improve internal care delivery practices and advance the interoperable exchange of health information across care partners to improve communication and care coordination. The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of health information technology and promote nationwide health information exchange to improve health care. The Office of the National Coordinator for Health Information Technology (ONC) leads these efforts in collaboration with other agencies, including CMS and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). In 2015, ONC released a document entitled “Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap” (available at: <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>) which includes a near-term focus on actions that will enable a majority of individuals and providers across the care continuum to send, receive, find and use a common set of electronic clinical information at the nationwide level by the end of 2017. The 2015 Edition Health IT Certification Criteria (2015 Edition) builds on past rulemakings to facilitate greater interoperability for several clinical health information purposes and enables health information exchange through new and enhanced certification criteria, standards, and implementation

specifications. The 2015 Edition also focuses on the establishment of an interoperable nationwide health information infrastructure. More information on the ONC Health IT Certification Program is available at: <https://www.healthit.gov/policy-researchers-implementers/2015-edition-final-rule>

III. Provisions of the Proposed Rule

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

1. Hospice Payment Reform: Research and Analyses

a. Pre-Hospice Spending

In 1982, the Congress introduced hospice into the Medicare program as an alternative to aggressive curative treatment at the end of life. During the development of the benefit, multiple testimonies from industry leaders and hospice families were heard, and it was consistently reported that hospices provided high-quality, compassionate and humane care while also offering a reduction in Medicare costs.⁴ Additionally, a Congressional Budget Office (CBO) study asserted that hospice care would result in sizable savings over conventional hospital care.⁵ Those savings estimates were based on a comparison of spending in the last 6 months of life for a cancer patient not utilizing hospice care versus the cost of hospice care for the 6 months preceding

⁴ Subcommittee of Health of the Committee of Ways and Means, House of Representatives, March 25, 1982.

⁵ Mor V. Masterson-Allen S. (1987): *Hospice care systems: Structure, process, costs and outcome*. New York: Springer Publishing Company.

³ FFY15 Hospice Claims from CCW; Pulled Jan 06 2016

death.⁶ Therefore, the original language for section 1814(i) of the Act (prior to August 29, 1983) set the hospice aggregate cap amount at 40 percent of the average Medicare per capita expenditure amount for cancer patients in the last 6 months of life. Recent analysis conducted by MedPAC showed that hospice appears to modestly raise end-of-life costs.⁷ While hospice reduces costs for cancer decedents on average, hospice does not reduce costs for individuals with long hospice stays.

Analysis was conducted to evaluate pre-hospice spending for beneficiaries who used hospice and who died in FY 2014. To evaluate pre-hospice spending, we calculated the median daily Medicare payments for such beneficiaries for the 180 days, 90 days, and 30 days prior to electing hospice care. We then categorized patients according to the principal diagnosis reported on the hospice claim. The

analysis revealed that for some patients, the Medicare payments in the 180 days prior to the hospice election were lower than Medicare payments associated with hospice care once the benefit was elected (see Table 3). Specifically, median Medicare spending for a beneficiary with a diagnosis of Alzheimer's disease, non-Alzheimer's dementia, or Parkinson's in the 180 days prior to hospice admission (about 20 percent of patients) was \$64.87 per day compared to the daily RHC rate of \$156.06 in FY 2014. Closer to hospice admission, the median Medicare payments per day increase, as would be expected as the patient approaches the end of life and patient needs intensify. However, 30 days prior to a hospice election, median Medicare spending was \$96.99 for patients with Alzheimer's disease, non-Alzheimer's dementia, or Parkinson's. In contrast,

the median Medicare payments prior to hospice election for patients with a principal hospice diagnosis of cancer were \$143.48 in the 180 days prior to hospice admission and increased to \$293.64 in the 30 days prior to hospice admission. The average length of stay for hospice elections where the principal diagnosis was reported as Alzheimer's disease, non-Alzheimer's Dementia, or Parkinson's is greater than patients with other diagnoses, such as cancer, Cerebral Vascular Accident (CVA)/stroke, chronic kidney disease, and Chronic Obstructive Pulmonary Disease (COPD). For example, the average lifetime length of stay for an Alzheimer's, non-Alzheimer's Dementia, or Parkinson's patient in FY 2014 was 119 days, compared to 47 days for patients with a principal diagnosis of cancer (or in other words, 150 percent longer).

TABLE 3—MEDIAN PRE-HOSPICE SPENDING ESTIMATES AND INTERQUARTILE RANGE BASED ON 180, 90, AND 30 DAY LOOK-BACK PERIODS PRIOR TO INITIAL HOSPICE ADMISSION WITH ESTIMATES OF AVERAGE LIFETIME LENGTH OF STAY (LOS) BY PRIMARY DIAGNOSIS AT HOSPICE ADMISSION, FY 2014

Primary Hospice Diagnosis at Admission	Estimates of Daily Non-Hospice Medicare Spending Prior to First Hospice Admission									Mean Lifetime Total Hospice Days
	180 Day Look-Back			90 Day Look-Back			30 Day Look-Back			
	25th Pct.	Median	75th Pct.	25th Pct.	Median	75th Pct.	25th Pct.	Median	75th Pct.	
All Diagnoses	\$46.92	\$117.77	\$241.97	\$55.70	\$157.92	\$340.24	\$58.07	\$268.98	\$548.00	73.9
Alzheimer's, Dementia, and Parkinson's	22.56	64.87	160.29	22.16	78.62	216.75	20.18	96.99	357.49	118.8
CVA/Stroke	51.05	111.22	233.33	70.13	158.29	338.67	102.64	320.20	588.60	55.6
Cancers	62.37	143.48	268.44	77.91	188.66	364.64	80.81	293.64	576.16	47.3
Chronic Kidney Disease	87.81	203.97	389.33	117.38	273.72	524.18	174.13	435.90	796.26	29.8
Heart (CHF and Other Heart Disease)	57.03	130.15	251.14	72.85	177.45	357.43	84.57	308.69	572.53	78.8
Lung (COPD and Pneumonias) ...	63.10	140.46	268.43	87.05	196.62	396.02	114.58	360.29	676.46	69.4
All Other Diagnoses	44.75	115.05	245.91	54.25	158.65	357.24	59.98	285.65	590.73	78.2

Source: All Medicare Parts A, B, and D claims for FY 2014 from the Chronic Conditions Data Warehouse (CCW) retrieved February, 2016. Note(s): Estimates drawn from FY2014 hospice decedents who were first-time hospice admissions, ages 66+ at hospice admission, admitted since 2006, and not enrolled in Medicare Advantage prior to admission. All payments are inflation-adjusted to September 2014 dollars using the Consumer Price Index (Medical Care; All Urban Consumers).

In the FY 2014 Hospice Wage Index and Payment Rate Update proposed and final rules (78 FR 27843 and 78 FR 48272, respectively), we discussed whether a case mix system could be created in future refinements to differentiate hospice payments according to patient characteristics. Analyzing pre-hospice spending was undertaken as an initial step in determining whether patients required different resource needs prior to hospice based on the principal diagnosis reported on the hospice claim. Table 3 indicates that hospice patients with the

longest length of stay had lower pre-hospice spending relative to hospice patients with shorter lengths of stay. These hospice patients tend to be those with neurological conditions, including those with Alzheimer's disease, other related dementias, and Parkinson's disease. Typically, these conditions are associated with longer disease trajectories, progressive loss of functional and cognitive abilities, and more difficult prognostication.

b. Non-hospice Spending

When a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made, except for services provided by the designated hospice and the attending physician. Hospice services are to be comprehensive and inclusive and we have reiterated since 1983 that "virtually all" care needed by the terminally ill individual would be provided by hospice, given the

⁶ Fogel, Richard. (1983): *Comments on the Legislative Intent of Medicare's Hospice Benefit* (GAO/HRD-83-72).

⁷ Hogan, C. (2015): *Spending in the Last Year of Life and the Impact of Hospice on Medicare Outlays*. <http://www.medpac.gov/documents/>

contractor-reports/spending-in-the-last-year-of-life-and-the-impact-of-hospice-on-medicare-outlays-(updated-august-2015).pdf?sfvrsn=0

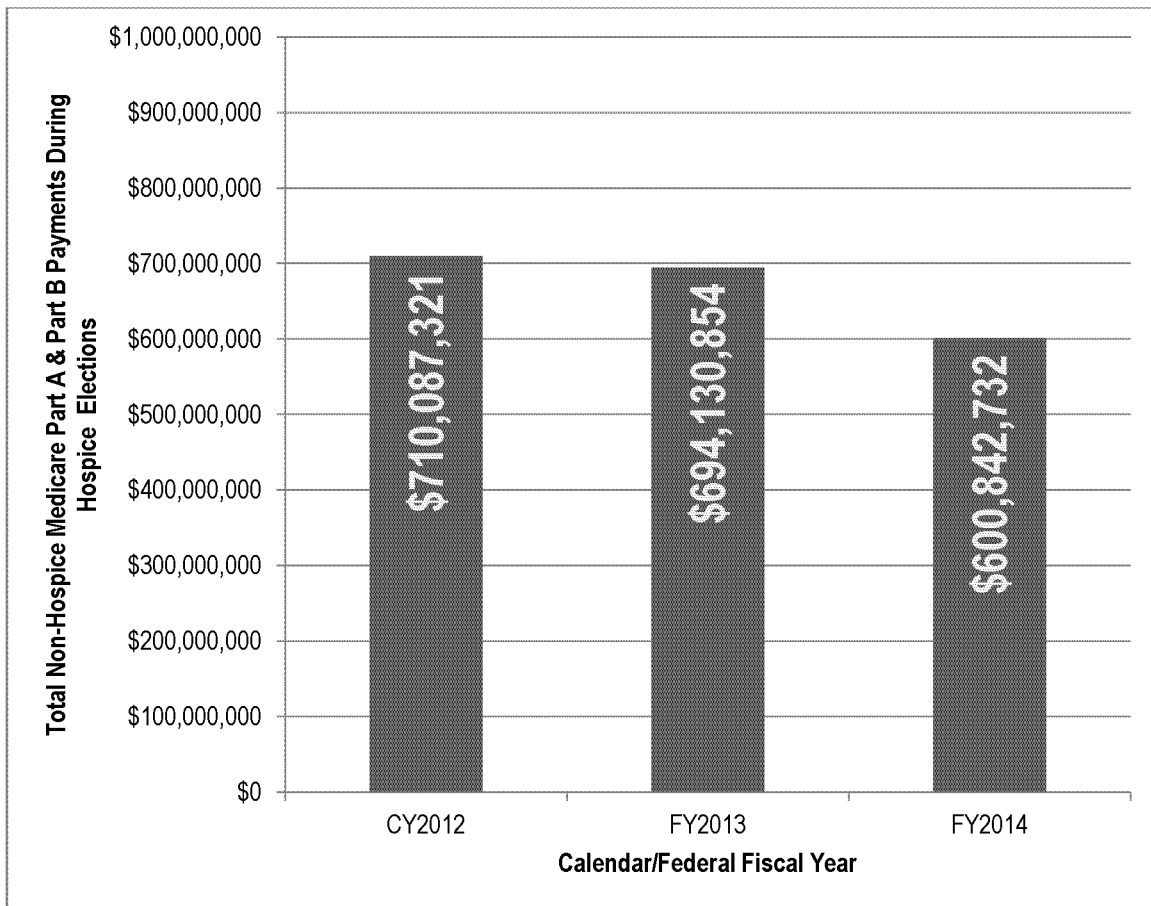
interrelatedness of body systems. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life. However, we have conducted ongoing analysis of non-hospice spending during a hospice election over the past several years and this analysis seems to suggest unbundling of services that perhaps should have been provided and covered under the Medicare hospice benefit.

We reported initial findings on CY 2012 non-hospice spending during a

hospice election in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452) and FY 2013 non-hospice spending during a hospice election in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47153). In this rule, we updated our analysis of non-hospice spending during a hospice election using FY 2014 data. Medicare payments for non-hospice Part A and Part B services received by hospice beneficiaries during hospice election

were \$710.1 million in CY 2012, \$694.1 million in FY 2013, and \$600.8 million in FY 2014 (See Figure 1). Non-hospice spending has decreased each year since we began reporting these findings: down 2.2 percent from CY 2012 to FY 2013 and then down 13.4 percent in from FY 2013 to FY 2014—a much more significant decline. Overall, from CY 2012 to FY 2014 non-hospice spending during hospice election declined 15.4 percent.

Figure 1: Medicare Payments for Non-Hospice Medicare Part A and Part B Services During Hospice Elections, CY 2012, FY 2013, and FY 2014



Note(s): Analysis of 100 percent Medicare Part A and Part B Standard Analytic Files, CY 2012 through FY 2014, excluding utilization on hospice admission or live discharge days.

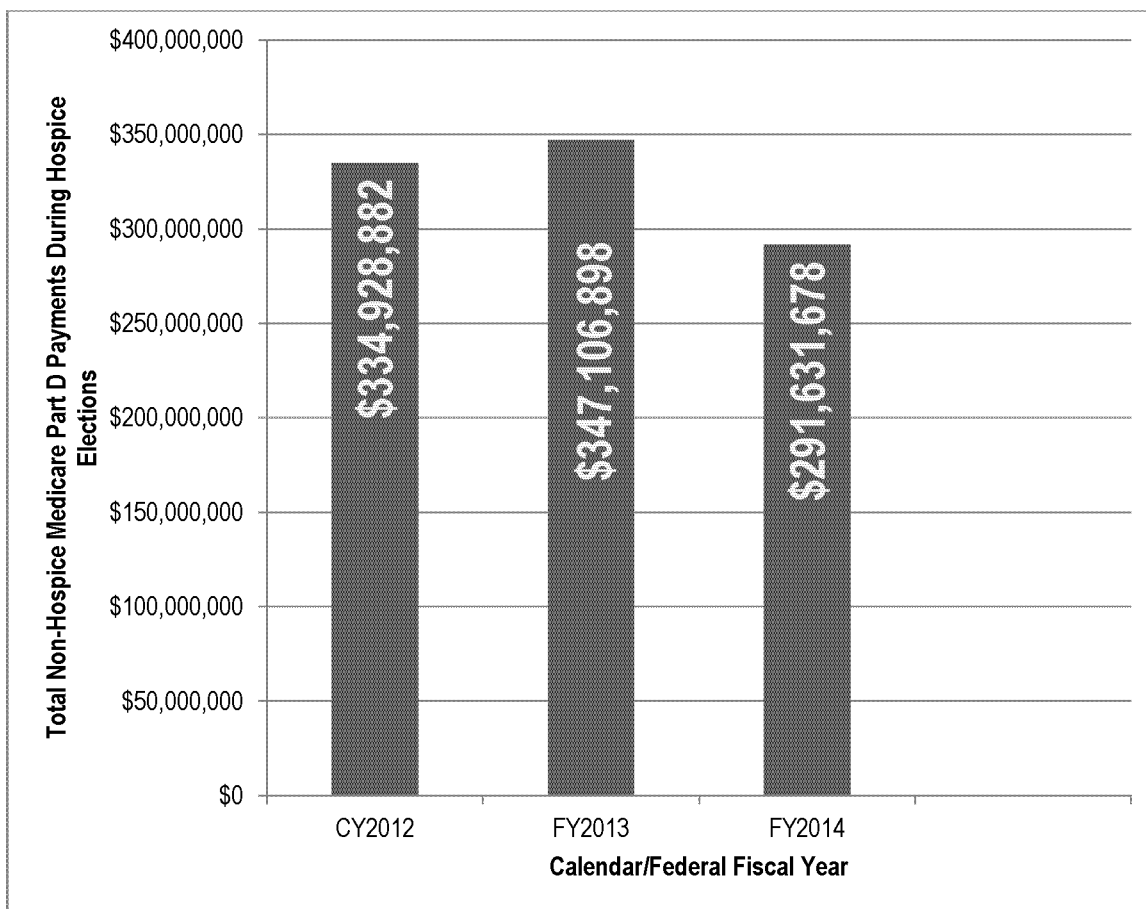
Hospice beneficiaries had \$122.5 million in Parts A and B cost-sharing for items and services that were billed to Medicare Parts A and B for a total of \$723.3 million for FY 2014.

We also examined Part D for CY 2012 and FY 2013 spending for those

beneficiaries under a hospice election and reported those findings in our FY 2015 and FY 2016 hospice final rules, respectively. We updated our analysis of FY 2014 Part D Prescription Drug Event data, which shows Medicare payments for non-hospice Part D drugs received

by hospice beneficiaries during a hospice election were \$334.9 million in CY 2012, \$347.1 million in FY 2013, and \$291.6 million in FY 2014 (see Figure 2).

Figure 2: Medicare Payments for Non-Hospice Medicare Part D Services During Hospice Elections, CY 2012, FY 2013, and FY 2014



Source: Analysis of 100% CY 2012 through FY 2014 Medicare Claim Files. +

Table 4 details the various components of Part D spending for patients receiving hospice care. The portion of the \$371.7 million total Part D spending that was paid by Medicare is the sum of the Low Income Cost-Sharing Subsidy and the Covered Drug Plan Paid Amount, or \$291.6 million.

TABLE 4—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES’ FY 2014 DRUGS RECEIVED THROUGH PART D

Component	FY 2014 expenditures
Patient Pay Amount	\$41,722,567
Low Income Cost-Sharing Subsidy	95,389,484
Other True Out-of-Pocket Amount	1,704,601
Patient Liability Reduction due to Other Payer Amount	12,816,746

TABLE 4—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES’ FY 2014 DRUGS RECEIVED THROUGH PART D—Continued

Component	FY 2014 expenditures
Covered Drug Plan Paid Amount	196,242,194
Non-Covered Plan Paid Amount	18,428,208
Six Payment Amount Totals ...	366,303,799
Unknown/Unreconciled	5,374,873
Gross Total Drug Costs, Reported	371,678,672

Source: Analysis of 100% FY 2014 Medicare Claim Files. For more information on the components above and on Part D data, go to the Research Data Assistance Center’s (ResDAC’s) Web site at: <http://www.resdac.org/>.

We further analyzed Part D drug expenditures by the top twenty most frequently reported principal diagnoses on hospice claims for beneficiaries under a hospice election. These Part D expenditures included those for common palliative drugs, which include analgesics (anti-inflammatory, non-narcotic, and opioids), antianxiety agents, antiemetics, and laxatives. The analysis also includes other drugs typically associated with the conditions reported. Table 5 details Part D spending for hospice beneficiaries by the top twenty most frequently reported principal diagnoses on hospice claims. Overlapping hospice claims are defined as claims for any Part D drugs that were dispensed on a day that the beneficiary also received hospice care.

TABLE 5—SUMMARY OF OVERLAPPING PART D DRUGS BY TOP 20 MOST FREQUENTLY REPORTED HOSPICE PRINCIPAL DIAGNOSES IN FY 2014

Terminal condition		Drug therapeutic classification	Number of hospice beneficiaries	Hospice beneficiaries (%)	Number of overlapping hospice claims	Number of Part D Rx	Part D gross drug payment (\$)
3D-DGN	Description						
331	Cerebral Degenerations.	.....	167,677	12.6	.....	.....	.....
		Common Palliative Drugs			50,537	61,310	1,880,621
		Psychotherapeutic and Neurological Agents—Misc.			48,764	72,774	11,563,443
428	Heart Failure	Antipsychotics/Antimanic Agents	132,174	9.9	35,307	46,857	3,229,221
		Common Palliative Drugs			38,110	46,448	1,589,113
		Cardiovascular Agents—Misc			509	602	1,243,362
		Antihypertensives			24,889	29,843	783,221
		Antianginal Agents			11,118	13,085	688,201
		Diuretics			38,081	50,186	485,243
		Beta Blockers			29,545	32,833	480,877
		Vasopressors			775	857	71,657
162	Lung Cancer .....	.....	100,984	7.6	.....	.....	.....
		Common Palliative Drugs			20,689	25,723	1,182,222
		Antineoplastics and Adjunctive Therapies.			2,042	2,217	2,093,837
294	Mental Disorder (Chronic).	.....	81,364	6.1	.....	.....	.....
		Common Palliative Drugs			26,355	32,457	971,792
		Psychotherapeutic and Neurological Agents—Misc.			21,181	31,800	4,868,784
496	COPD	Antipsychotics/Antimanic Agents	79,267	6.0	18,076	24,244	1,826,575
		Common Palliative Drugs			33,098	42,194	1,941,201
		Antiasthmatic and Bronchodilator Agents.			30,968	47,903	8,768,675
		Respiratory Agents—Misc			41	47	289,214
290	Mental Disorder (Senile & Presenile).	.....	70,852	5.3	.....	.....	.....
		Corticosteroids			11,600	13,516	195,780
		Common Palliative Drugs			24,206	29,992	877,181
		Psychotherapeutic and Neurological Agents—Misc.			19,923	29,954	4,527,689
429	Other Heart Diseases	.....	51,616	3.9	.....	.....	.....
		Antipsychotics/Antimanic Agents			16,323	21,700	1,555,710
		Common Palliative Drugs			16,072	19,902	735,511
		Antihyperlipidemics			14,071	16,122	657,115
		Antihypertensives			11,363	13,585	394,125
		Cardiovascular Agents—Misc			152	167	379,608
		Antianginal Agents			4,821	5,778	378,205
		Beta Blockers			11,955	13,190	203,521
		Diuretics			12,378	15,606	152,209
		Calcium Channel Blockers			5,880	6,462	115,265
		Vasopressors			374	420	29,475
436	Stroke(Acute) .....	.....	33,766	2.5	.....	.....	.....
		Common Palliative Drugs			7,349	8,871	270,278
		Antihypertensives			7,397	9,257	245,294
		Antihyperlipidemics			6,776	8,019	239,749
		Anticoagulants			1,948	3,318	236,426
		Hematological Agents—Misc			3,602	4,006	216,792
		Beta Blockers			7,044	7,988	103,034
		Calcium Channel Blockers			4,698	5,467	72,363
		Cardiotonics			1,198	1,336	36,175
		Diuretics			4,149	5,119	34,962
		Cardiovascular Agents—Misc			22	24	24,149
		Vasopressors			90	94	7,624
332	Parkinson's disease	.....	30,906	2.3	.....	.....	.....
		Common Palliative Drugs			10,305	12,639	388,887
		Antiparkinson Agents			15,969	22,317	2,470,058
		Psychotherapeutic and Neurological Agents—Misc.			10,059	14,280	2,331,283
		Antipsychotics/Antimanic Agents			6,581	8,859	809,845
585	Chronic Renal Failure.	.....	27,945	2.1	.....	.....	.....
		Common Palliative Drugs			4,888	6,026	191,297
		Hematological Agents—Misc			1,204	1,350	57,443
		Diuretics			3,292	4,266	44,415
		Nutrients			92	138	21,096
		Minerals & Electrolytes			775	921	17,458
		Vitamins			22	22	123
438	Stroke(Late Effect) ...	.....	27,443	2.1	.....	.....	.....
		Common Palliative Drugs			7,178	8,974	275,151
		Antihypertensives			6,813	8,557	233,267
		Anticoagulants			1,827	3,281	200,116
		Antihyperlipidemics			5,310	6,159	195,822

TABLE 5—SUMMARY OF OVERLAPPING PART D DRUGS BY TOP 20 MOST FREQUENTLY REPORTED HOSPICE PRINCIPAL DIAGNOSES IN FY 2014—Continued

Terminal condition		Drug therapeutic classification	Number of hospice beneficiaries	Hospice beneficiaries (%)	Number of overlapping hospice claims	Number of Part D Rx	Part D gross drug payment (\$)	
3D-DGN	Description							
157	Pancreatic Cancer	Hematological Agents—Misc			2,989	3,311	184,818	
		Beta Blockers			7,192	8,170	109,777	
		Calcium Channel Blockers			4,635	5,427	75,992	
		Diuretics			3,826	4,991	36,531	
		Cardiovascular Agents—Misc			22	29	23,212	
			26,858	2.0				
518	Lung Diseases	Common Palliative Drugs			4,809	5,854	302,932	
		Digestive Aids			554	610	269,356	
		Antineoplastics and Adjunctive Therapies.			367	403	146,428	
			26,683	2.0				
414	Ischemic Heart Disease.	Common Palliative Drugs			3,045	3,719	129,314	
		Antiasthmatic and Bronchodilator Agents.			1,704	2,515	396,030	
					754	854	11,081	
			26,673	2.0				
153	Colon Cancer	Common Palliative Drugs			8,831	10,882	425,098	
		Antihyperlipidemics			7,927	8,987	367,409	
		Antianginal Agents			3,741	4,577	276,861	
		Antihypertensives			6,448	7,674	222,786	
		Beta Blockers			6,817	7,506	117,183	
		Cardiovascular Agents—Misc			32	37	61,455	
		Calcium Channel Blockers			3,163	3,492	54,946	
		Cardiotonics			1,164	1,272	33,187	
					26,668	2.0		
							5,906	7,458	322,177
174	Breast Cancer	Antineoplastics and Adjunctive Therapies.			523	574	387,221	
			25,174	1.9				
185	Prostate Cancer	Common Palliative Drugs			7,080	9,151	384,738	
		Antineoplastics and Adjunctive Therapies.			2,529	2,855	680,720	
			22,334	1.7				
491	Chronic bronchitis	Common Palliative Drugs			4,446	5,655	293,249	
		Antineoplastics and Adjunctive Therapies.			1,500	1,668	2,363,693	
			18,846	1.4				
437	Other Cerebrovascular Disease.	Common Palliative Drugs			6,469	8,157	364,686	
			17,859	1.3				
155	Liver Cancer	Common Palliative Drugs			3,991	4,907	164,769	
		Common Palliative Drugs			3,317	4,174	166,550	
		Antineoplastics and Adjunctive Therapies.			300	326	1,106,663	

Source: CWF Claims Data, Prescription Drug TAP, Medicare Enrollment Database. Claims data through 12/18/2015. Included all beneficiaries with a paid hospice claim (excluding hospice claims for pre-election counselling and evaluation services) for which Part D drugs were filled on a day that the beneficiary also received hospice care.

Hospices are required to cover drugs for the palliation and management of the terminal prognosis; we remain concerned that common palliative and other disease-specific drugs for hospice beneficiaries are being covered and paid for through Part D. Because hospices are required to provide a comprehensive range of services, including drugs, to Medicare beneficiaries under a hospice election, we believe that Medicare could be paying twice for drugs that are already covered under the hospice per diem payment by also paying for them under Part D.⁸

⁸ oig.hhs.gov/oas/region6/61000059.pdf
“Medicare Could Be Paying Twice for Prescriptions For Beneficiaries in Hospice.”

Total non-hospice spending paid by either Medicare or by beneficiaries that occurred during a hospice election was \$723.3 million (\$600.8 million Medicare spending plus \$122.5 million in beneficiary cost-sharing liabilities) for Parts A and B plus \$371.6 million (\$291.6 million Medicare spending plus \$80 million in beneficiary cost-sharing liabilities) for Part D spending, or approximately \$1.1 billion dollars total in FY 2014.

c. Live Discharge Rates

Currently, federal regulations allow a beneficiary who has elected to receive Medicare hospice services to revoke their hospice election at any time and for any reason. Specifically, the

regulations state that if the hospice beneficiary (or his/her representative) revokes the hospice election, Medicare coverage of hospice care for the remainder of that period is forfeited. The beneficiary may, at any time, re-elect to receive hospice coverage for any other hospice election period that he or she is eligible to receive (§ 418.24(e) and § 418.28(c)(3)). During the time period between revocation/discharge and the re-election of the hospice benefit, Medicare coverage would resume for those Medicare benefits previously waived. A revocation can only be made by the beneficiary, in writing, that he or she is revoking the hospice election and the effective date of the revocation. A hospice cannot “revoke” a beneficiary’s

hospice election, nor is it appropriate for hospices to encourage, request or demand that the beneficiary revoke his or her hospice election. Like the hospice election, a hospice revocation is to be an informed choice based on the beneficiary's goals, values and preferences for the services they wish to receive through Medicare.

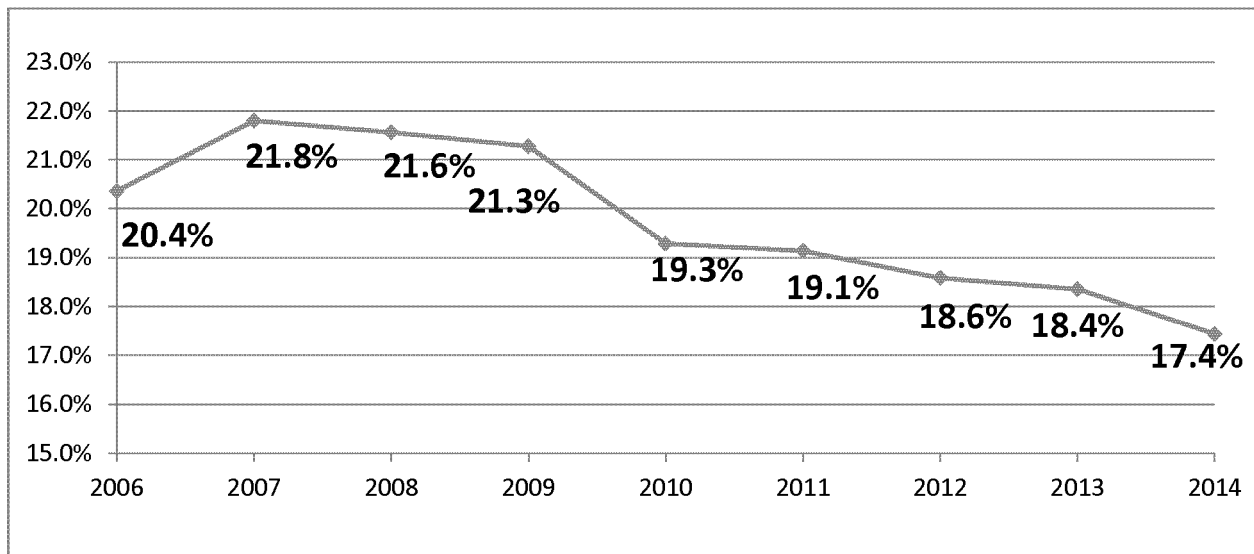
Federal regulations limit the circumstances in which a Medicare hospice provider may discharge a patient from its care. In accordance with § 418.26, discharge from hospice care is permissible when the patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause. Hospices may not discharge the patient at their discretion,

even if the care may be costly or inconvenient for the hospice program. As we indicated in the FY 2015 Hospice Wage Index and Payment Rate Update proposed and final rules, we understand that the rate of live discharges should not be zero, given the uncertainties of prognostication and the ability of beneficiaries and their families to revoke the hospice election at any time. On July 1, 2012, we began collecting discharge information on the claim to capture the reason for all types of discharges which includes, death, revocation, transfer to another hospice, moving out of the hospice's service area, discharge for cause, or due to the beneficiary no longer being considered terminally ill (that is, no longer

qualifying for hospice services). Based upon the additional discharge information, Abt Associates, our research contractor performed analysis on FY 2014 claims to identify those beneficiaries who were discharged alive. In order to better understand the characteristics of hospices with high live discharge rates, we examined the aggregate cap status, skilled visit intensity; average lengths of stay; and non-hospice spending rates per beneficiary.

While Figure 3 demonstrates an incremental decrease in average annual rates of live discharge rates from 2006 to 2014, peaking in 2007, there has been a leveling off at around 18 percent over the past several years.

Figure 3: Annual Average Live Discharge Rates for FYs 2006 through 2014



Source: FY 2014 claims from SSS Analytic File.

Among hospices with 50 or more discharges (discharged alive or deceased), there is significant variation in the rate of live discharge between the 10th and 90th percentiles (see Table 6). Most notably, hospices at the 95th percentile discharged 50 percent or more of their patients alive in FY 2014.

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

Statistic	Live discharge rate (%)
5th Percentile	7.4
10th Percentile	8.9
25th Percentile	12.3
Median	17.5
75th Percentile	26.2

TABLE 6—DISTRIBUTION OF LIVE DISCHARGE RATES IN FY 2014 FOR HOSPICES WITH 50 OR MORE LIVE DISCHARGES—Continued

Statistic	Live discharge rate (%)
90th Percentile	39.1
95th Percentile	50.0
Note: n = 3,135 .....	.....

Source: FY 2014 claims from SSS Analytic File.

In FY 2014, we found that hospices with high live discharge rates also, on average, provided fewer visits per week. Those hospices with live discharge rates at or above the 90th percentile provided, on average, 4.05 visits per week. Hospices with live discharge rates below the 90th percentile provided, on

average, 4.73 visits per week. We also found in FY 2014 that, when focusing on visits classified as skilled nursing or medical social services, hospices with live discharge rates at or above the 90th percentile provided, on average, 1.88 visits per week versus hospices with live discharge rates below the 90th percentile that provided, on average, 2.34 visits per week.

We examined whether there was a relationship between hospices with high live discharge rates, average lengths of stay, and non-hospice spending per beneficiary per day (see Table 7 and Figure 2). Hospices with patients that, on average, accounted for \$27 per day in non-hospice spending while in hospice (decile 10 in Table 7 and Figure 4) had live discharge rates that were, on average, about 34.7 percent and had an

average lifetime length of stay of 158 days. In contrast, hospices with patients that, on average, accounted for only \$3.66 per day in non-hospice spending while in a hospice election (decile 1 in Table 7 and Figure 4) had live discharge

rates that were, on average, about 18.2 percent and had an average lifetime length of stay of 99.8 days. In other words, hospices in the highest decile, according to their level of non-hospice spending for patients in a hospice

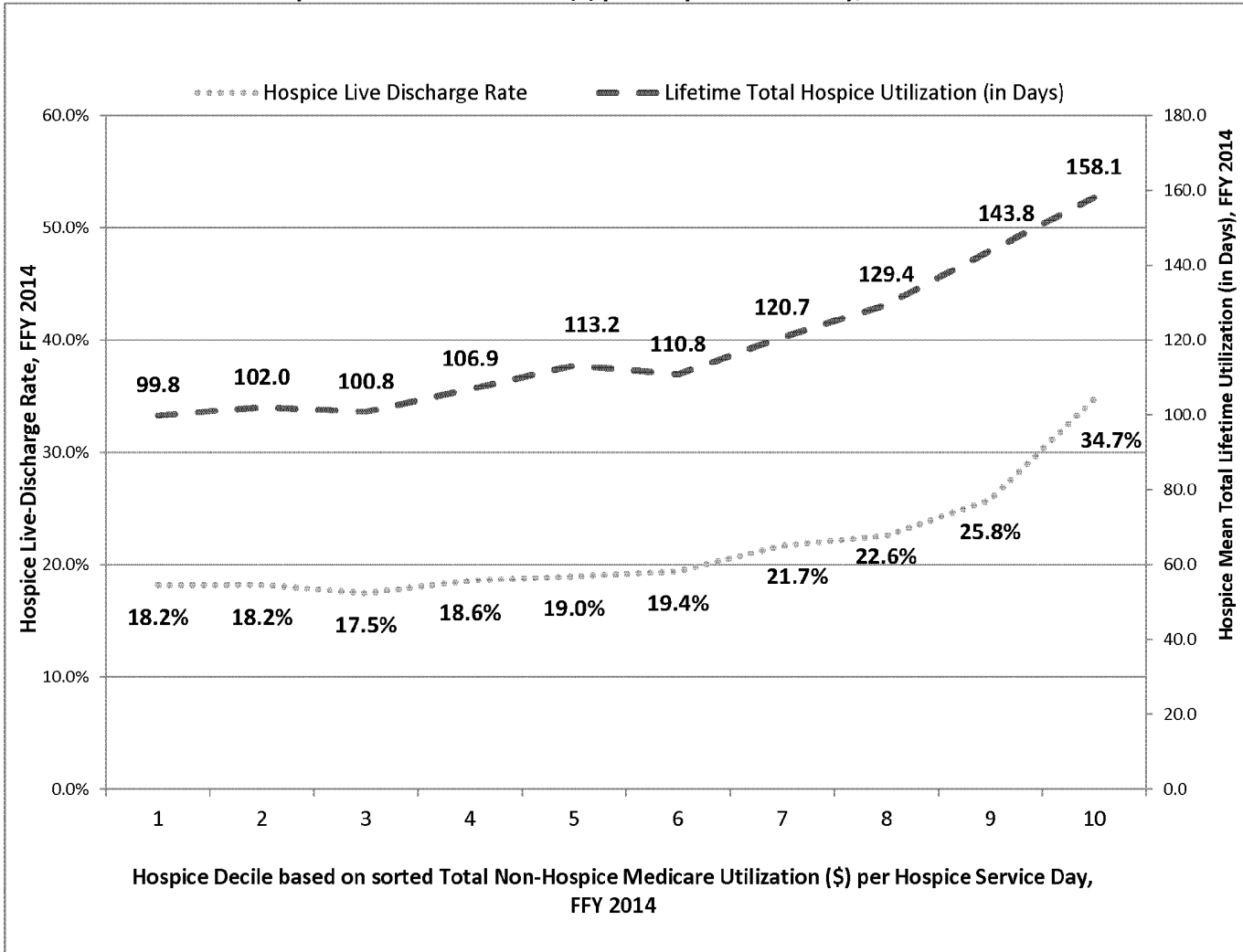
election, had live discharge rates and average lifetime lengths of stay that averaged 90 percent and 58 percent higher, respectively, than the hospices in lowest decile.

TABLE 7—MEAN DAILY NON-HOSPICE MEDICARE UTILIZATION AND SUM TOTAL NON-HOSPICE UTILIZATION BY HOSPICE PROVIDER DECILE BASED ON SORTED NON-HOSPICE MEDICARE UTILIZATION PER HOSPICE DAY, FY 2014

Decile	Non-hospice Medicare (\$) per hospice service day	Total non-hospice Medicare (\$)
1	\$3.66	\$21,981,020
2	5.50	39,167,526
3	6.88	52,038,093
4	8.11	67,119,545
5	9.26	79,829,044
6	10.63	99,430,439
7	12.12	143,575,036
8	14.03	163,323,857
9	16.84	162,402,299
10	26.60	233,419,872
All Hospices	11.37	1,062,286,730

Note: Analysis of 100 percent Medicare Analytic Files, FY 2014. Cohort is hospices with 50+ total discharges in FY 2014 [n = 3,135]. Hospice deciles are based on estimates of total non-hospice Medicare utilization (\$) per hospice service day, excluding utilization on hospice admission or live discharge days.

Figure 4: Live Discharge Rates and Mean Total Lifetime Hospice Utilization (in Days) by Decile of Non-Hospice Medicare Utilization (\$) per Hospice Service Day, FFY 2014



Note: Analysis of 100 percent Medicare Analytic Files, FFY 2014. Cohort is hospices with 50+ total discharges in FFY 2014 [n=3,135]. Hospice deciles are based on estimates of total non-hospice Medicare utilization (\$) per hospice service day, excluding utilization on hospice admission or live discharge days; total lifetime hospice utilization is calculated as mean of FFY 2014 beneficiaries that last used the hospice; live discharge rates are calculated as percentage of beneficiaries discharged alive, FFY 2014.

The analytic findings in Table 7 and Figure 4 suggest that some hospices may be using the Medicare Hospice program inappropriately as a long-term care (“custodial”) benefit rather than an end of life benefit for terminal beneficiaries. As previously discussed in reports by MedPAC, there is a concern that hospices may be admitting beneficiaries who do not legitimately meet hospice eligibility criteria. Additionally, the Office of the Inspector General (OIG), has raised concerns about the potential for hospices to target beneficiaries who have long lengths of stay or certain diagnoses because they may offer the hospices the greatest financial gain.⁹ We

continue to communicate and collaborate across CMS to improve monitoring and oversight activities of hospice activities. We expect to analyze more recent hospice claims and cost report data as they become available to determine whether additional regulatory proposals to reform and strengthen the Medicare hospice benefit are warranted.

d. Skilled Visits in the Last Days of Life

As we noted in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47164), we are concerned that many beneficiaries are not receiving skilled visits during the last few days of life. At the end of life, patient needs typically surge and more intensive services are warranted. However, analysis of FY 2014 claims data shows that on any given day during

the last 7 days of a hospice election, nearly 47 percent of the time the patient has not received a skilled visit (skilled nursing or social worker visit) (see Table 8). Moreover, on the day of death nearly 26 percent of beneficiaries did not receive a skilled visit (skilled nursing or social work visit). While Table 8 shows the frequency and length of skilled nursing and social work visits combined during the last 7 days of a hospice election in FY 2014, Tables 9 and 10 show the frequency and length of visits for skilled nursing and social work separately. Analysis of FY 2014 claims data shows that on any given day during the last 7 days of a hospice election, almost 49 percent of the time the patient had not received a visit by a skilled nurse, and 91 percent of the time the patient had not received a visit by a

⁹ Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities OEI-02-14-00070.

social worker (see Tables 9 and 10, respectively). We believe it is important to assure that beneficiaries and their families and caregivers are, in fact, receiving the level of care necessary during critical periods such as the very end of life.

TABLE 8—FREQUENCY AND LENGTH OF SKILLED NURSING AND SOCIAL WORK VISITS (COMBINED) DURING THE LAST SEVEN DAYS OF A HOSPICE ELECTION, FY 2014

Visit length	Day of death	One day before death (%)	Two days before death (%)	Three days before death (%)	Four days before death (%)	Five days before death (%)	Six days before death (%)	Last seven days combined (%)
No visit	25.8	39.0	45.7	50.2	53.5	56.2	58.5	46.3
15 mins to 1 hr	24.6	28.5	26.6	25.4	24.3	23.5	22.7	25.1
1 hr 15 m to 2 hrs	24.9	19.1	17.1	15.6	14.4	13.4	12.6	16.9
2 hrs 15 m to 3 hrs	12.7	7.0	5.7	4.9	4.4	4.1	3.5	6.3
3 hrs 15 m to 3 hrs 45m ..	4.4	2.3	1.8	1.6	1.3	1.2	1.1	2.0
4 or more hrs	7.6	4.2	3.0	2.4	2.1	1.8	1.6	3.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: FY 2014 hospice claims data from the Standard Analytic Files for CY 2013 (as of June 30, 2014) and CY 2014 (as of December 31, 2015).

TABLE 9—FREQUENCY AND LENGTH OF SKILLED NURSING VISITS DURING THE LAST SEVEN DAYS OF A HOSPICE ELECTION, FY 2014

Visit length	Day of death	One day before death (%)	Two days before death (%)	Three days before death (%)	Four days before death (%)	Five days before death (%)	Six days before death (%)	Last seven days combined (%)
No visit	27.2	41.6	48.6	53.1	56.5	59.2	61.5	48.9
15 mins to 1 hr	25.1	29.5	27.1	25.5	24.3	23.3	22.3	25.5
1 hr 15 m to 2 hrs	25.2	18.6	16.5	14.8	13.6	12.6	11.8	16.4
2 hrs 15 m to 3 hrs	12.3	5.5	4.4	3.7	3.3	2.9	2.6	5.2
3 hrs 15 m to 3 hrs 45m ..	4.0	1.7	1.3	1.0	0.8	0.8	0.8	1.6
4 or more hrs	6.3	3.2	2.2	1.8	1.5	1.3	1.2	2.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: FY 2014 hospice claims data from the Standard Analytic Files for CY 2013 (as of June 30, 2014) and CY 2014 (as of December 31, 2015).

TABLE 10—FREQUENCY AND LENGTH OF SOCIAL WORK VISITS DURING THE LAST SEVEN DAYS OF A HOSPICE ELECTION, FY 2014

Visit length	Day of death	One day before death (%)	Two days before death (%)	Three days before death (%)	Four days before death (%)	Five days before death (%)	Six days before death (%)	Last seven days combined (%)
No visit	91.6	89.1	90.2	90.9	91.5	91.9	92.3	91.0
15 mins to 1 hr	4.9	7.1	6.4	6.1	5.7	5.5	5.2	5.8
1 hr 15 m to 2 hrs	2.5	3.1	2.8	2.6	2.4	2.2	2.1	2.6
2 hrs 15 m to 3 hrs	0.6	0.6	0.4	0.3	0.2	0.2	0.2	0.4
3 hrs 15 m to 3 hrs 45m ..	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
4 or more hrs	0.2	0.1	0.1	0.0	0.0	0.0	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: FY 2014 hospice claims data from the Standard Analytic Files for CY 2013 (as of June 30, 2014) and CY 2014 (as of December 31, 2015).

A recent article published in the Journal of American Medicine (JAMA) titled “Examining Variation in Hospice Visits by Professional Staff in the Last 2 Days of Life” also highlighted concerns regarding the lack of visits by professional hospice staff (defined as nursing staff (RN and LPN), social workers, nurse practitioners, or physicians) in the last days of a hospice

episode. This study found that, of the 661,557 Medicare hospice beneficiaries who died in FY 2014, 81,478 (12.3 percent) received no professional staff visits in the last 2 days of life. Furthermore, professional staff from 281 hospice programs, with at least 30 discharges during federal fiscal year 2014, did not visit any of their patients who were entitled to have received such

RHC services during the last 2 days of life. Additionally, the investigation demonstrated that black patients and frail, older adults residing in nursing homes and enrolled in Medicare hospice often did not receive visits from hospice staff in the last 2 days of life, raising concerns over disparities of care. The authors believe that further research is needed in order to understand

whether a lack of visits by professional staff affects the quality of care for the dying person and their family.¹⁰ The last week of life is typically the period in the terminal illness trajectory with the highest symptom burden. Particularly during the last few days before death, patients experience a myriad of physical and emotional symptoms, necessitating close care and attention from the integrated hospice team. Several organizations and panels have identified care of the imminently dying patient as an important domain of palliative and hospice care and established guidelines and recommendations related to this high priority aspect of healthcare that affects a large number of people. This is discussed further in section III.C.6, Proposed Updates to the Hospice Quality Reporting Program, where a new hospice quality reporting measure is proposed, "Hospice Visits when Death is Imminent". We believe that the implementation of the Service Intensity Add-on (SIA) payment, finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47164 through 47177), represents an incremental step toward encouraging higher frequency of much-needed end of life care by encouraging visits during beneficiaries' most intensive time of need for skilled care—the last 7 days of life.

2. Monitoring for Impacts of Hospice Payment Reform

As noted above, in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142), we finalized the creation of two RHC rates—one RHC rate for the first 60 days of hospice care and a second RHC rate for days 61 and beyond. As noted in section III.A.1.d, in the same final rule, we also created a SIA payment. The SIA payment is paid in addition to the RHC per diem payment for direct care provided by a RN or social worker in the last 7 days of life. The two RHC rates and the SIA payment became effective on January 1, 2016. The goal of these hospice payment reform changes is to more accurately align hospice payment with resource utilization while encouraging appropriate, high-quality hospice care, and maximizing beneficiary, family, and caregiver satisfaction with care. As noted in the FY 2016 final rule, as data become available, we will monitor the impact of

the hospice payment reform changes finalized in the rule as well as continue to monitor general hospice trends to help inform future policy efforts and program integrity measures. This monitoring and analysis will include, but not be limited to, monitoring hospice diagnosis reporting, lengths of stay, live discharge patterns and their relationship with the provision of services and the aggregate cap, non-hospice spending for Parts A, B and D during a hospice election, trends of live discharge at or around day 61 of hospice care, and readmissions after a 60 day lapse since live discharge.

Specifically, we will work with our monitoring contractor, Acumen LLC, to conduct comprehensive, real time monitoring and analysis of hospice claims to help identify program vulnerabilities, as well as potential areas of fraud and abuse. To monitor overall usage and payment trends in hospice, Acumen will track monthly and annual changes in the following metrics.

1. Percentage of Medicare beneficiaries electing hospice
2. Total number of Medicare hospice patients
3. Demographic and geographic location characteristics among Medicare hospice patients
4. Number and share of Medicare hospice patients presenting with various terminal conditions, aggregated by broader clinical categories
5. Total payment for hospice care (also by level of care)
6. Number and share of live discharges
7. Number and rate of readmissions
8. Average length of episodes
9. Proportion of days by level of care (RHC, CHC, general inpatient care (GIP), and inpatient respite care (IRC))
10. Volume and payments for non-hospice services used during hospice stays

Additionally, to address policy impacts, specifically for the hospice payment reform provisions finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule, Acumen will longitudinally monitor the effect of changes in the RHC payment rate on volume and payments for hospice care using the following metrics:

1. Average length of hospice stays
2. Total number and share of live discharges
3. Average readmissions rates within or after 60 days

Acumen will monitor the effects of the new SIA payment policy using the following metrics:

1. Total number of nursing visits (also separately for RNs and LPNs)
2. Total number of visits by social workers
3. Average number of services billed per discharge
4. Average number of hours billed per discharge and per hospice day
5. Average number of services billed during the first 7 days, middle of a stay, and last 7 days of a hospice stay
6. Intensity of services billed during the first 7 days, middle of a stay, and last 7 days of a hospice stay

These measures are further broken down by level of care (for example, RHC versus CHC) to understand the effect of the SIA payment policy on incentivizing care at the RHC level.

The monitoring analysis can be examined at the aggregate level as well as at the individual provider level. This comprehensive and provider-level monitoring will not only inform future policymaking decisions but targeted program integrity efforts as well.

In addition to Acumen LLC's comprehensive, real time monitoring and analysis of hospice claims, we have developed a hospice Program for Evaluating Payment Patterns Electronic Reports (PEPPER), which generates informational tables provided to hospices that summarize provider-specific Medicare data statistics for target areas often associated with Medicare improper payments due to billing, coding and/or admission necessity issues. The intent of the hospice PEPPER is to help inform hospices of potential program administration and other vulnerabilities to provide the opportunity for improvement. Specifically, these reports can be used to compare performance of a specific hospice to that of other hospices in various geographic delineations, including the nation, specific MAC jurisdictions, and states. PEPPER can also be used to compare data statistics over time to identify changes in billing practices, to pinpoint areas in need of auditing and monitoring, identify other potential problems and to help hospices achieve CMS' goal of reducing and preventing improper payments. The hospice PEPPER provides various metrics, including several markers of live discharges on various time intervals, markedly long lengths of stay, as well as information regarding levels and frequency of hospice care provided in various settings. Recently added metrics include differentiating reasons for live discharges (for example, beneficiary being no longer terminally ill, patient

¹⁰ Teno, J., Plotzke, M., Christian, T. & Gozalo, P. (2016). Examining Variation in Hospice Visits by Professional Staff in the Last 2 Days of Life. *Journal of American Medicine Internal Medicine*. Published online February 8, 2016. doi:10.1001/jamainternmed.2015.7479.

revocations), live discharges with length of stay between 61 to 179 days, claims with a single diagnosis coded, and hospice episodes of care when no GIP or CHC is provided.

B. Proposed FY 2017 Hospice Wage Index and Rate Update

1. Proposed FY 2017 Hospice Wage Index

a. Background

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

We use the previous FY's hospital wage index data to calculate the hospice wage index values. For FY 2017, the hospice wage index will be based on the FY 2016 hospital pre-floor, pre-reclassified wage index. This means that the hospital wage data used for the hospice wage index is not adjusted to take into account any geographic reclassification of hospitals including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic area in which the beneficiary resides when receiving 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 Inpatient Respite Care (IRC).

In the FY 2006 Hospice Wage Index final rule (70 FR 45130), we adopted the changes discussed in the OMB Bulletin No. 03-04 (June 6, 2003). This bulletin announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas. The bulletin is available online at <http://www.whitehouse.gov/omb/bulletins/b03-04.html>.

When adopting OMB's new labor market designations in FY 2006, we identified some geographic areas where there were no hospitals, and thus, no hospital wage index data, which to base the calculation of the hospice wage index. In the FY 2010 Hospice Wage Index final rule (74 FR 39386), we adopted the policy that for urban labor

markets without a hospital from which hospital wage index data could be derived, all of the CBSAs within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. In FY 2016, the only CBSA without a hospital from which hospital wage data could be derived is 25980, Hinesville-Fort Stewart, Georgia.

In the FY 2008 Hospice Wage Index final rule (72 FR 50214), we implemented a new methodology to update the hospice wage index for rural areas without a hospital, and thus no hospital wage data. In cases where there was a rural area without rural hospital wage data, we used 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, our policy of imputing a rural pre-floor, pre-reclassified hospital wage index value based on the pre-floor, pre-reclassified hospital wage index (or indices) of CBSAs contiguous to a rural area without a hospital from which hospital wage data could be derived does not recognize the unique circumstances of Puerto Rico. In this proposed rule, for FY 2017, we propose to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

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 then 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.

b. FY 2016 Implementation of New Labor Market Delineations

OMB has published subsequent bulletins regarding CBSA changes. 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. A copy of this bulletin is available online at: <http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf>. This bulletin states that it "provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246-37252) and Census Bureau data." In the FY 2016 Hospice Wage Index final rule (80 FR 47178), we adopted the OMB's new area delineations using a 1-year transition. In the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47178), we stated that beginning October 1, 2016, the wage index for all hospice payments would be fully based on the new OMB delineations.

The proposed wage index applicable for FY 2017 is available on the CMS Web site at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html>. The proposed wage index applicable for FY 2017 will not be published in the **Federal Register**. The proposed hospice wage index for FY 2017 would be effective October 1, 2016 through September 30, 2017.

2. Proposed Hospice Payment Update Percentage

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) 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 index 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 for that FY. The Act requires us to use the inpatient hospital market basket to determine the hospice payment rate update. In addition, section 3401(g) of the Affordable Care

Act mandates that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. 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) (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the "MFP adjustment"). A complete description of the MFP projection methodology is available on our Web site at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html>.

In addition to the MFP adjustment, section 3401(g) of the Affordable Care Act also mandates that in FY 2013 through FY 2019, the hospice payment update percentage will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act). The proposed hospice payment update percentage for FY 2017 is based on the estimated inpatient hospital market basket update of 2.8 percent (based on IHS Global Insight, Inc.'s first quarter 2016 forecast with historical data through the fourth quarter of 2015). Due to the requirements at 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the estimated inpatient hospital market basket update for FY 2017 of 2.8 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.5 percentage point for FY 2017). The estimated inpatient hospital market basket update for FY 2017 is reduced further by 0.3 percentage point, as mandated by the Affordable Care Act. In effect, the proposed hospice payment update percentage for FY 2017 is 2.0 percent. We are also proposing that if more recent data are subsequently available (for example, a more recent estimate of the inpatient hospital market basket update and MFP adjustment), we would use such data, if appropriate, to determine the FY 2017 market basket

update and the MFP adjustment in the FY 2017 Hospice Rate Update final rule.

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.

3. Proposed FY 2017 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 continuous home care, IRC, or general inpatient care. CHC is provided during a period of patient crisis to maintain the person at home; IRC is short-term care to allow the usual caregiver to rest and be relieved from caregiving; and GIP is to treat symptoms that cannot be managed in another setting.

As discussed in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 61 and beyond. In addition, in the final rule, we adopted a Service Intensity Add-on (SIA) payment, when direct patient care is provided by a RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the day of service, if certain criteria are met. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by a SIA budget neutrality factor.

As discussed in the FY 2016 Hospice Wage Index and Payment Rate Update

final rule (80 FR 47177), we will continue to make the SIA payments budget neutral through an annual determination of the SIA budget neutrality factor (SBNF), which will then be applied to the RHC payment rates. The SBNF will be calculated for each FY using the most current and complete FY utilization data available at the time of rulemaking. For FY 2017, the budget neutrality adjustment that would apply to days 1 through 60 is calculated to be 1.0001. The budget neutrality adjustment that would apply to days 61 and beyond is calculated to be 0.9999.

For FY 2017, we are proposing to apply a wage index standardization factor to the FY 2017 hospice payment rates in order to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data. Wage index standardization factors are applied in other payment settings such as under home health Prospective Payment System (PPS), IRF PPS, and SNF PPS. Applying a wage index standardization factor to hospice payments would eliminate the aggregate effect of annual variations in hospital wage data. We believe that adopting a hospice wage index standardization factor would provide a safeguard to the Medicare program as well as to hospices because it would mitigate fluctuations in the wage index by ensuring that wage index updates and revisions are implemented in a budget neutral manner. To calculate the wage index standardization factor, we simulated total payments using the FY 2017 hospice wage index and compared it to our simulation of total payments using the FY 2016 hospice wage index. By dividing payments for each level of care using the FY 2017 wage index by payments for each level of care using the FY 2016 wage index, we obtain a wage index standardization factor for each level of care (RHC days 1–60, RHC days 61+, CHC, IRC, and GIP).

Lastly, the hospice payment rates for hospices that submit the required quality data would be increased by the full proposed FY 2017 hospice payment update percentage of 2.0 percent as discussed in section III.C.3. The proposed FY 2017 RHC rates are shown in Table 11. The proposed FY 2017 payment rates for CHC, IRC, and GIP are shown in Table 12.

TABLE 11—PROPOSED FY 2017 HOSPICE RHC PAYMENT RATES

Code	Description	FY 2016 payment rates	SBNF	Proposed wage index standardization factor	FY 2017 proposed hospice payment update percentage	FY 2017 proposed payment rates
651	Routine Home Care (days 1–60)	\$186.84	× 1.0001	× 0.9990	× 1.020	\$190.41
651	Routine Home Care (days 61+)	146.83	× 0.9999	× 0.9995	× 1.020	149.68

TABLE 12—PROPOSED FY 2017 HOSPICE CHC, IRC, AND GIP PAYMENT RATES

Code	Description	FY 2016 payment rates	Proposed wage index standardization factor	FY 2017 proposed hospice payment update percentage	FY 2017 proposed payment rates
652	Continuous Home Care Full Rate = 24 hours of care 40.16 = FY 2017 hourly rate	\$944.79	× 1.0000	× 1.020	\$963.69
655	Inpatient Respite Care	167.45	× 1.0000	× 1.020	170.80
656	General Inpatient Care	720.11	× 0.9996	× 1.020	734.22

Sections 1814(i)(5)(A) through (C) of the Act require that hospices begin submitting quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index final rule (76 FR 47320 through 47324), we implemented a Hospice Quality Reporting Program (HQRP) as required by section 3004 of the

Affordable Care Act. Hospices were required to begin collecting quality data in October 2012, and submit that quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the

quality data submission requirements with respect to that FY. The proposed FY 2017 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2017 hospice payment update percentage of 2.0 percent minus 2 percentage points. These rates are shown in Tables 13 and 14.

TABLE 13—PROPOSED FY 2017 HOSPICE RHC PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2016 payment rates	SBNF	Proposed wage index standardization factor	FY 2017 proposed hospice payment update of 2.0% minus 2 percentage points = 0.0%	FY 2017 proposed payment rates
651	Routine Home Care (days 1–60)	\$186.84	× 1.0001	× 0.9990	× 1.000	\$186.67
651	Routine Home Care (days 61+)	146.83	× 0.9999	× 0.9995	× 1.000	146.74

TABLE 14—PROPOSED FY 2017 HOSPICE CHC, IRC, AND GIP PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2016 payment rates	Proposed wage index standardization factor	FY 2017 proposed hospice payment update of 2.0% minus 2 percentage points = 0.0%	FY 2017 proposed payment rates
652	Continuous Home Care Full Rate = 24 hours of care \$39.37 = FY 2017 hourly rate	\$944.79	× 1.0000	× 1.000	\$944.79
655	Inpatient Respite Care	167.45	× 1.0000	× 1.000	167.45
656	General Inpatient Care	720.11	× 0.9996	× 1.000	719.82

4. Hospice Cap Amount for FY 2017

As discussed in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47183), we implemented changes mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Specifically, for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the consumer price index for urban consumers (CPI-U). As required by section 1814(i)(2)(B)(ii) of the Act, the hospice cap amount for the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016, is equal to the 2015 cap amount (\$27,382.63) updated by the FY 2016 hospice payment update percentage of 1.6 percent. As such, the 2016 cap amount is \$27,820.75.

In the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142), we finalized aligning the cap accounting year with the federal fiscal year beginning in 2017. Therefore, the 2017 cap year will start on October 1, 2016 and end on September 30, 2017. Table 26 in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47185) outlines the timeframes for counting beneficiaries and payments during the 2017 transition year. The hospice cap amount for the 2017 cap year will be \$28,377.17, which is equal to the 2016 cap amount (\$27,820.75) updated by the FY 2017 hospice payment update percentage of 2.0 percent.

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

1. Background and Statutory Authority

Section 3004(c) of the Affordable Care Act amended section 1814(i)(5) of the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points could result in the annual market basket update being less than 0.0 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 FY involved. Any such reduction would

not be cumulative or be taken into account in computing the payment amount for subsequent FYs. Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form, manner, and at a time specified by the Secretary.

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

Any measures selected by the Secretary must be endorsed by the consensus-based entity, which holds a contract regarding performance measurement, including the endorsement of quality measures, with the Secretary under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). However, section 1814(i)(5)(D)(ii) of the Act provides that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus-based entity, the Secretary may specify measures that are not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary. Our paramount concern is the successful development of a HQRP that promotes the delivery of high quality healthcare services. We seek to adopt measures for the HQRP that promote person-centered, high quality, and safe care. Our measure selection activities for the HQRP take into consideration input from the Measure Applications Partnership (MAP), convened by the NQF, as part of the established CMS pre-rulemaking process required under section 1890A of the Act. The MAP is a public-private partnership comprised of multi-stakeholder groups convened by the NQF for the primary purpose of providing input to CMS on the selection of certain categories of quality and efficiency measures, as required by section 1890A(a)(3) of the Act. By February 1st of each year, the NQF must provide that input to CMS. Input from the MAP is located at: http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx. We also take into account national priorities, such as those established by the National Priorities Partnership at (<http://www.qualityforum.org/npp/>), the HHS Strategic Plan (<http://www.hhs.gov/secretary/about/priorities/priorities.html>), the National Strategy for Quality Improvement in Healthcare, (<http://www.ahrq.gov/workingfor>

[quality/nqs/nqs2013annlrpt.htm](http://www.quality/nqs/nqs2013annlrpt.htm)) and the CMS Quality Strategy (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Quality-InitiativesGenInfo/CMS-Quality-Strategy.html>). To the extent practicable, we have sought to adopt measures endorsed by member organizations of the National Consensus Project (NCP), recommended by multi-stakeholder organizations, and developed with the input of providers, purchasers/payers, and other stakeholders.

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

In the FY 2016 Hospice Wage Index final rule, for the purpose of streamlining the rulemaking process, we stated that when we adopt measures for the HQRP beginning with a payment determination year, these measures would automatically be adopted for all subsequent years' payment determinations, unless we proposed to remove, suspend, or replace the measures. Quality measures would be considered for removal by CMS if:

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

For any such removal, the public would be given an opportunity to comment through the annual rulemaking process. However, if there was reason to believe continued collection of a measure raised potential safety concerns, we would take immediate action to remove the measure from the HQRP and not wait for the annual rulemaking cycle. The measures would be promptly removed and we would immediately notify hospices and the public of such a decision through the usual CMS HQRP communication channels, including postings and

announcements on the CMS HQRP Web site, Medicare Learning Network (MLN) eNews communications, National provider association calls, and announcements on Open Door Forums and Special Open Door Forums. In such instances, the removal of a measure would be formally announced in the next annual rulemaking cycle.

To further streamline the rulemaking process, we propose to codify that if measures we are using in the HQRP undergo non-substantive changes in the specifications as part of their NQF re-endorsement process, we would subsequently utilize the measure with their new endorsed status in the HQRP without going through new notice-and-comment rulemaking. As mentioned previously, quality measures selected for the HQRP must be endorsed by the NQF unless they meet the statutory criteria for exception under section 1814(i)(5)(D)(ii) of the Act. The NQF is a voluntary consensus standard-setting organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other healthcare stakeholder organizations. The NQF was established to standardize healthcare quality measurement and reporting through its consensus measure development process (http://www.qualityforum.org/About_NQF/Mission_and_Vision.aspx). The NQF undertakes review of: (1) New quality measures and national consensus standards for measuring and publicly reporting on performance; (2) regular maintenance processes for endorsed quality measures; (3) measures with time limited endorsement for consideration of full endorsement; and (4) ad hoc review of endorsed quality measures, practices, consensus standards, or events with adequate justification to substantiate the review. Through NQF's measure maintenance process, NQF-endorsed measures are sometimes updated to incorporate changes that we believe do not substantially change the nature of the measure. Examples of such changes could be updated diagnosis or procedure codes, or changes to exclusions to a particular patient/consumer population or definitions. We believe these types of maintenance changes are distinct from more substantive changes to measures. Additionally, since the NQF endorsement and measure maintenance process is one that ensures transparency, public input, and discussion among representatives across the healthcare enterprise,¹¹ we believe

that the NQF measure endorsement and maintenance process itself is transparent, scientifically rigorous, and provides opportunity for public input. Thus, we propose to codify at § 418.312 that if the NQF makes only non-substantive changes to specifications for HQRP measures in the NQF's re-endorsement process we would continue to utilize the measure in its new endorsed status. If NQF-endorsed specifications change and we do not adopt those changes, then we would propose the measure as an application (that is, with CMS modifications). An application of a NQF-endorsed quality measure is utilized in instances when we have identified a need to use a NQF-endorsed measure in a QRP, but needs to use it with one or more modifications to the quality measure's specifications. We may modify one or more of the following aspects of a NQF-endorsed quality measure: (1) Numerator; (2) denominator; (3) setting; (4) look-back period; (5) calculation period; (6) risk adjustment; and (7) revisions to data elements used to collect the data the data required for the measure. Reasons for not adopting changes in measure specifications may include any of the aforementioned criteria for removal, including that the new specification does not align with clinical guidelines or practice, or that the new specification leads to negative unintended consequences. Finally, we will continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures we have adopted for the HQRP. We continue to make these determinations about what constitutes a substantive vs non-substantive change on a measure-by-measure basis. We will continue to provide updates about changes to measure specifications as a result of NQF endorsement or maintenance processes through the normal CMS HQRP communication channels, including postings and announcements on the CMS HQRP Web site, MLN eNews communications, National provider association calls, and announcements on Open Door Forums and Special Open Door Forums.

4. Previously Adopted Quality Measures for FY 2017 and FY 2018 Payment Determination

As stated in the CY 2013 HH PPS final rule (77 FR 67068 through 67133), We expanded the set of required measures to include additional measures endorsed by NQF. We also stated that to support the standardized collection and calculation of quality measures by CMS,

collection of the needed data elements would require a standardized data collection instrument. In response, we developed, tested, and implemented a hospice patient-level item set, the HIS. Hospices are required to submit a HIS-Admission record and a HIS-Discharge record for each patient admission to hospice since July 1, 2014. In developing the standardized HIS, we considered comments offered in response to the CY 2013 HH PPS proposed rule (77 FR 41548 through 41573). 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 6 NQF endorsed measures and 1 modified measure 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) (modified).

To achieve a comprehensive set of hospice quality measures available for widespread use for quality improvement and informed decision making, and to carry out our commitment to develop a quality reporting program for hospices that uses standardized methods to collect data needed to calculate quality measures, we finalized the HIS effective July 1, 2014 (78 FR 48258). To meet the quality reporting requirements for hospices for the FY 2016 payment determination and each subsequent year, we require regular and ongoing electronic submission of the HIS data for each patient admission to hospice after July 1, 2014, regardless of payer or patient age (78 FR 48234 through 48258). We finalized a requirement in the FY 2014 Hospice Wage Index final rule (78 FR 48258) that hospice providers collect data on all patients to ensure that all patients regardless of payer or patient age are receiving the same care and that provider metrics measure performance across the spectrum of patients.

Hospices are required to complete and submit a HIS-Admission and a HIS-Discharge record for each patient admission. Hospices failing to report quality data via the HIS for patient admissions occurring in 2016 will have their market basket update reduced by 2 percentage points in FY 2018 (beginning in October 1, 2017). In the FY 2015 Hospice Wage Index final rule (79 FR 50485 through 50487), we

¹¹ "NQF: How Endorsement Happens—National Quality Forum." 2010. 26 Jan. 2016 http://www.qualityforum.org/Measuring_Performance/ABCs/How_Endorsement_Happens.aspx.

www.qualityforum.org/Measuring_Performance/ABCs/How_Endorsement_Happens.aspx.

finalized the proposal to codify the HIS submission requirement at § 418.312. The System of Record (SOR) Notice

titled “Hospice Item Set (HIS) System,” SOR number 09–70–0548, was

published in the **Federal Register** on April 8, 2014 (79 FR 19341).

TABLE 15—PREVIOUSLY FINALIZED QUALITY MEASURES AFFECTING THE FY 2017 PAYMENT DETERMINATION AND SUBSEQUENT YEAR

Quality measure	NQF ID No.	Type	Submission method	Data submission deadlines
Treatment Preferences	1641	Process Measure ...	Hospice Item Set	Within 30 days of patient admission or discharge (Event Date).
Beliefs/Values Addressed	1647			
Pain Screening	1634			
Pain Assessment	1637			
Dyspnea Screening	1639			
Dyspnea Treatment	1638			
Patients Treated with an Opioid who are Given a Bowel Regimen.	1617			

5. Proposed Removal of Previously Adopted Measures

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

6. Proposed New Quality Measures for FY 2019 Payment Determinations and Subsequent Years and Concepts Under Consideration for Future Years

a. Background and Considerations in Developing New Quality Measures for the HQRP

As noted in section III.E.2 of this proposed rule, our paramount concern is to develop quality measures that promote care that is person-centered, high quality, and safe. In identifying priority areas for future measure enhancement and development, we take into consideration input from numerous stakeholders, including the MAP, the MedPAC, Technical Expert Panels (TEP), and national priorities, such as those established by the National Priorities Partnership, the HHS Strategic Plan, the National Strategy for Quality Improvement in Healthcare, and the CMS Quality Strategy. In addition, we takes into consideration vital feedback and input from research published by our payment reform contractor, as well as important observations and recommendations contained in the Institute of Medicine (IOM) report, titled “Dying in America”, released in

September 2014.¹² Finally, the current HQRP measure set is also an important consideration for future measure development areas; future measure development areas should complement the current HQRP measure set, which includes HIS measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey measures.

As stated in the FY 2016 Hospice Wage Index final rule (80 FR 47188), based on input from stakeholders, we identified several high priority areas for future measure development, including: A patient reported pain outcome measure; claims-based measures focused on care practices patterns, including skilled visits in the last days of life; responsiveness of the hospice to patient and family care needs; and hospice team communication and care coordination. Of the aforementioned measure areas, we have pursued measure development for 2 quality measures: Hospice Visits when Death is Imminent Measure Pair, and Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission. These measures were included on CMS’ List of Measures under Consideration (MUC list) for 2015, and discussed at the MAP meeting on December 14 and 15, 2015. All materials related to the MUC list and the MAP’s recommendations for each measure can be found on the National Quality Forum Web site, MAP Post-Acute Care/Long-Term Care Workgroup Web page at: <http://www.qualityforum.org/ProjectMaterials.aspx?projectID=75370>. The MAP supported the direction of each proposed measure.

¹² IOM (Institute of Medicine). 2014. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press.

b. New Quality Measures for the FY 2019 Payment Determination and Subsequent Years

We are proposing 2 new quality measures for the HRQP 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.

(1) Proposed Quality Measure 1: Hospice Visits When Death is Imminent Measure Pair

Measure Background. This measure set addresses whether a hospice patient and their caregivers’ needs were addressed by the hospice staff during the last days of life. This measure is specified as a set of 2 measures as follows:

Measure 1—assesses the percentage of patients receiving at least 1 visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life and addresses case management and clinical care.

Measure 2—assesses the percentage of patients receiving at least 2 visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides in the last 7 days of life and gives providers the flexibility to provide individualized care that is in line with the patient, family, and caregiver’s preferences and goals for care and contributing to the overall well-being of the individual and others important in their life.

Measure Importance. The last week of life is typically the period in the terminal illness trajectory with the highest symptom burden. Particularly during the last few days before death, patients experience myriad physical and emotional symptoms, necessitating close care and attention from the

integrated hospice team. Hospice responsiveness during times of patient and caregiver need is an important aspect of care for hospice consumers. In addition, clinician visits to patients at the end of life have been demonstrated to be associated with improved outcomes such as decreased risk of hospitalization, emergency room visits, and hospital death, and decreased distress for caregivers and higher satisfaction with care.

Several organizations and panels have identified care of the imminently dying patient as an important domain of palliative and hospice care and established guidelines and recommendations related to this high priority aspect of healthcare that affects a large number of people. The NQF 2006 report *A Framework for Preferred Practices for Palliative Care Quality*¹³ and the NCP Clinical Practice Guidelines for Quality Palliative Care¹⁴ recommend that signs and symptoms of impending death are recognized, communicated and educated, and care appropriate for the phase of illness is provided. The American College of Physicians Clinical Practice Guidelines¹⁵ recommend that clinicians regularly assess pain, dyspnea, and depression for patients with serious illness at the end of life. These measures address this high priority area by assessing hospice staff visits to patients and caregivers during the final days of life when patients and caregivers typically experience higher symptom and caregiving burdens, and therefore a higher need for care.

Measure Impact. The literature shows that health care providers' practice is responsive to quality measuring and reporting.¹⁶ We believe that this research, while not specific to hospices, reasonably predicts the effect of measures on hospice provider behavior. Collecting information about hospice staff visits for measuring quality of care, in addition to the requirement of reporting visits from some disciplines on hospice claims, will encourage

hospices to visit patients and caregivers and provide services that will address their care needs and improve quality of life during the patients' last days of life.

Performance Gap. The 2014 Abt Medicare Hospice Payment Reform Report indicated that 28.9 percent of Routine Home Care hospice patients did not receive a skilled visit on the last day of life.¹⁷ The Report defines a 'skilled visit' as a visit from a nurse, social worker, or therapist. This percentage could be, in part, a result of rapid decline and unexpected death. The report revealed variation in receipt of visits at the end of life related to multiple factors. Patients who died on a weekday rather than a weekend, patients with a very short length of stay (5 days or less), and patients aged 84 and younger were more likely to receive a skilled visit in the last 2 days of life. Smaller hospices and hospices in operation for 5 years or less were slightly less likely to provide a visit at the end of life. States with the lowest rates of no visits in the last days of life were some of the more rural states (ND, WI, TN, KS, VT), whereas states with the highest rates of no visits were more urban (NJ, MA, OR, WA, MN).

Existing Measures. This quality measure set will fill a gap by addressing hospice care provided at the end of life. No current HQRPs address care beyond the hospice initial and comprehensive assessment period, nor do any current HQRPs relate to the assessment of hospice staff visits to patients and caregivers in the last week of life.

Stakeholder Support. A TEP convened by our measure development contractor, RTI International, on May 7 and 8, 2015, provided input on the measure concept. The TEP agreed that hospice visits when death is imminent is an important concept to measure and supported data collection using the HIS. A second TEP was convened October 19 and 21, 2015, to provide input on the technical specifications of this quality measure pair. The TEP supported development of a measure set rather than a single measure, using different timeframes to measure the different types of care provided, and limiting the measures to patients receiving routine home care. The NQF MAP met on December 14th and 15th, 2015 and provided input to CMS. The MAP encouraged continued development of the Hospice Visits when Death is Imminent measure pair in the HQRPs.

More information about the MAP's recommendations for this measure is available at: <http://www.qualityforum.org/ProjectMaterials.aspx?projectID=75370>. While this measure is not currently NQF endorsed, we recognize that the NQF endorsement process is an important part of measure development and plan to submit this measure pair for NQF endorsement.

Form, Manner, and Timing of Data Collection and Submission. Data for this measure would be collected via the existing data collection mechanism, the HIS. We have proposed that 4 new items be added to the HIS-Discharge record to collect the necessary data elements for this measure. We expect that data collection for this quality measure via the 4 new HIS items would begin no earlier than April 1, 2017. Thus, under our current timelines, hospice providers would begin data collection for this measure for patient admissions and discharges occurring after April 1, 2017. Prior to the release of the new HIS data items, we will provide education and training to hospice providers to ensure all providers have adequate information and guidance to collect and submit data on this measure to CMS.

Since the data collection mechanism is the HIS, providers would collect and submit data using the same processes that are outlined in sections III.E.7c through III.E.7e of this proposed rule. In those sections, we specify that data for the measure would be submitted to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system, in compliance with the timeliness criterion and threshold set out.

For more information on the specifications and data elements for the measure set, Hospice Visits when Death is Imminent, we refer readers to the HQRPs Specifications for the Hospice Item Set-based Quality Measures document, available on the "Current Measures" portion of the CMS HQRPs Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>. In addition, to facilitate the reporting of HIS data as it relates to the implementation of the new measure, we submitted a request for approval to OMB for the Hospice Item Set version 2.00.0 under the Paperwork Reduction Act (PRA) process. The new HIS data items that would collect this measure data are also available for public viewing in the PRA package available at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/Paperwork-ReductionActof1995/PRA-Listing.html>.

¹³ National Quality Forum. *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*. 2006; Available from: http://www.qualityforum.org/publications/2006/12/A_National_Framework_and_PREFERRED_Practices_for_Palliative_and_Hospice_Care_Quality.aspx.

¹⁴ National Consensus Project. *Clinical Practice Guidelines for Quality Palliative Care*. 3rd edition. 2013, National Consensus Project: Pittsburgh, PA.

¹⁵ Qaseem, A., et al., *Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: A Clinical Practice Guideline from the American College of Physicians*. *Annals of Internal Medicine*, 2008. 148(2): p. 141-146.

¹⁶ Werner, R., E. Stuart, and D. Polsky, *Public reporting drove quality gains at nursing homes*. *Health Affairs*, 2010. 29(9): p. 1706-1713.

¹⁷ Plotzke, M., et al., *Medicare Hospice Payment Reform: Analyses to Support Payment Reform*. May 2014, Abt Associates Inc. Prepared for Centers for Medicare and Medicaid Services: Cambridge, MA.

We invite public comment on our proposal to implement the Hospice Visits when Death is Imminent measure pair beginning April 1, 2017, as previously

(2) Proposed Quality Measure 2: Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

Measure Background. The Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission is a composite measure that assesses whether a comprehensive patient assessment is completed at hospice admission by evaluating the number of individual care processes completed upon admission for each hospice patient stay. A composite measure, as defined by the NQF, is a combination of 2 or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score.¹⁸ For more information on composite measure definitions, guiding principles, and measure evaluation criteria, we refer readers to the NQF Composite Performance Measure Evaluation Guidance Publication available at: https://www.qualityforum.org/Publications/2013/04/Composite_Performance_Measure_Evaluation_Guidance.aspx. A total of 7 individual care processes will be captured in this composite measure, which include the 6 NQF-endorsed quality measures and 1 modified NQF-endorsed quality measure currently implemented in the HQRP. Thus, the Hospice and Palliative Care Composite Process quality measure will use the current HQRP quality measures as its components. These individual component measures address care processes around hospice admission that are clinically recommended or required in the hospice CoPs.¹⁹ This measure calculates the percentage of patients who received all care processes at admission. To calculate this measure, the individual component of the composite measure are assessed separately for each patient and then aggregated into one score for each hospice.

Measure Importance. This composite quality measure for comprehensive assessment at admission addresses high priority aspects of quality hospice care as identified by both leading hospice stakeholders and beneficiaries receiving

hospice services. The NCP for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care established 8 core palliative care domains, and this composite measure captures 4 of those domains.²⁰ The 4 domains captured by this composite measure are: The Structure and Process of Care Domain; the Physical Aspects of Care Domain; the Spiritual, Religious, and Existential Aspects of Care Domain, and the Ethical and Legal Aspects of Care Domain. The NCP guidelines placed equal weight on both the physical and psychosocial domains, emphasizing a comprehensive approach to patient care. For more information on the NCP domains for palliative care, refer to: http://www.nationalconsensusproject.org/guidelines_download2.aspx. In addition, the Medicare Hospice CoPs require that hospice comprehensive assessments identify patients' physical, psychosocial, emotional, and spiritual needs, and address them to promote the hospice patient's comfort throughout the end-of-life process. Furthermore, the person-centered, family, and caregiver perspective align with the domains identified by the CoPs and NCP, as patients and their families/caregiver also place value on physical symptom management and spiritual/psychosocial care as important factors at the end of life.^{21 22} A composite measure serves to ensure all hospice patients receive a comprehensive assessment for both physical and psychosocial needs at admission.

Measure Impact. The literature indicates that health care providers' practice is responsive to quality measures reported.²³ We believe this research, while not specific to hospices, reasonably predicts the effect of measures on hospice provider behavior. Collecting information about the total number of care processes conducted for each patient will incentivize hospices to conduct all desirable care processes for each patient and provide services that will address their care needs and improve quality during the time he/she is receiving hospice care. Additionally, creating a composite quality measure for

comprehensive assessment at admission will provide consumers and providers with a single measure regarding the overall quality and completeness of assessment of patient needs at hospice admission, which can then be used to meaningfully and easily compare quality across hospice providers and increase transparency.

Performance Gap. Analyses conducted by our measure development contractor, RTI International, show that hospice performance scores on the current 7 HQRP measures are high (a score of 90 percent or higher) however, these analyses also revealed that, on average, only 68.1 percent of patient stays in a hospice had documentation that all of these desirable care processes were done at admission. Thus, by assessing hospices' performance of comprehensive assessment, the composite measure sets a higher standard of care for hospices and reveals a larger performance gap. A similar effect has been shown in the literature where facilities are achieving more than 90 percent compliance with individual measures, but compliance numbers decrease when multiple measures are combined as one.^{24 25} 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.

Existing Measures. The Family Evaluation of Hospice Care (FEHC), NQF #0208, is a precursor of the Hospice CAHPS®. The surveys cover some similar domains. However, a major difference between them is the detailed requirements for survey administration of the CAHPS® Hospice Survey, which allow for comparison of hospice programs, The Hospice CAHPS® survey quality measure is not yet endorsed by NQF. We have recently submitted the CAHPS® Hospice Survey (experience of care) measure (NQF #2651) to be considered for endorsement under the Palliative and End-of-Life Care Project 2015–2016. For more information regarding this project and the measure submitted, we refer readers to <https://www.qualityforum.org/ProjectMeasures.aspx?projectId=80663>. In addition, we refer readers to section III.E.9 of this proposed rule for more information on the Hospice CAHPS® survey and associated quality

²⁰ The National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care 3rd edition 2013.

²¹ Singer PA, Martin DK, Kelner M. Quality End-of-Life Care: Patients' Perspectives. *JAMA*. 1999;281(2):163–168. doi:10.1001/jama.281.2.163.

²² Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers. *JAMA*. 2000;284(19):2476–2482. doi:10.1001/jama.284.19.2476.

²³ Werner, R., E. Stuart, and D. Polsky, *Public reporting drove quality gains at nursing homes*. *Health Affairs*, 2010. 29(9): p. 1706–1713.

²⁴ Nolan, T., & Berwick, D. M. (2006). All-or-none measurement raises the bar on performance. *JAMA* [H.W. Wilson—GS], 295(10), 1168.

²⁵ Agency for Healthcare Research and Quality. (2004). *National Healthcare Quality Report*.

¹⁸ National Quality Forum. (2013). *Composite Performance Measure Evaluation Guidance*: National Quality Forum.

¹⁹ Medicare and Medicaid Programs: Hospice Conditions of Participation, Part 418 subpart 54. Centers for Medicare and Medicaid Services, June 5, 2008.

measures. The CAHPS®-based quality measures submitted to NQF include patient and caregiver experience of care outcome measures, and our plan to propose these measures as part of the HQRP measure set in future rulemaking cycles. A key difference between the FEHC, Hospice CAHPS® and the Hospice and Palliative Care Composite Process Measure is that the FEHC and Hospice CAHPS® focus on the consumer’s perspective of their health agency and experience, whereas the Hospice and Palliative Care Composite Process Measure focuses on the clinical care processes that are actually delivered by the hospice to each patient.

Stakeholder Support. A TEP convened by our measure development contractor, RTI International, on December 2, 2015, provided input on this measure concept. The TEP unanimously agreed that a comprehensive hospice composite measure is an important measure and supported data collection using the HIS. The NQF MAP met on December 14th and 15th, 2015 and provided input to CMS. In their final recommendation, the MAP encouraged continued development of the Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission measure. More information about the MAP’s recommendations for this measure is available at: <http://www.qualityforum.org/ProjectMaterials.aspx?projectID=75370>.

While this measure is not currently NQF-endorsed, we recognize that the NQF endorsement process is an important part of measure development and plan to submit this measure for NQF endorsement. As noted, this quality measure will fill a gap by holding hospices to a higher standard of care and will motivate providers to conduct a greater number of high priority care processes for as many beneficiaries as possible upon admission as hospice patients. Furthermore, no current NQF-endorsed measures address the completion of a comprehensive care assessment at hospice admission.

Form, Manner, and Timing of Data Collection and Submission. The data source for this measure will be currently implemented HIS items that are currently used in the calculation of the 7 component measures. These items and quality measure algorithms for the 7 component measures can be found in the HQRP Specifications for the Hospice Item Set-based Quality Measures document, which is available in the “Downloads” section of the “Current Measures” portion of the CMS HQRP Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>. Since the proposed measure is a composite measure whose components are currently adopted HQRP measures, no new data collection will be required; data for the composite

measure will come from existing items from the existing 7 HQRP component measures. We propose to begin calculating this measure using existing data items, beginning April 1, 2017; this means patient admissions occurring after April 1, 2017 would be included in the composite measure calculation.

Since the composite measure components are existing HIS data items, providers are already collecting the data needed to calculate the composite measure. Data collection will continue in accordance with processes outlined in sections III.E.7c through III.E.7e of this proposed rule.

For more information on the specifications and data elements for the measure, Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission, we refer readers to the <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html> document, available on the “Current Measures” portion of the CMS HQRP Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>.

We invite public comment on our proposal to implement the Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission beginning April 1, 2017, as previously described for the HQRP.

TABLE 16—PROPOSED QUALITY MEASURES AND DATA COLLECTION PERIOD AFFECTING THE FY 2019 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

Quality measure	NQF ID No.	Type	Submission method	Data collection to begin
Hospice Visits when Death is Imminent	TBD	Process Measure	Hospice Item Set	04/01/2017
Hospice and Palliative Care Composite Process Measure.	TBD			

7. 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. Previously Finalized Policy for New Facilities To Begin Submitting Quality Data

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

In the FY 2016 Hospice Wage Index final rule (80 FR 47189), we further

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

from us, but will be subject to the APU reduction based on whether the CCN Notification letter was dated before or after November 1st of the reporting year involved. Thus, beginning with the FY 2018 payment determination and for each subsequent payment determination, we finalized our policy that a new hospice be responsible for HQRP quality data submission beginning on the date of the CCN notification letter; we retained our prior policy that hospices not be subject to the APU reduction if the CCN notification letter was dated after November 1st of the year involved. For example, if a provider receives their CCN notification letter and the date in the letterhead is November 5, 2016, that provider will begin submitting HIS data for patient admissions occurring after November 5, 2016. However, since the CCN notification letter was dated after November 1st, they would not be evaluated for, or subject to any payment penalties for the relevant FY APU update (which in this instance is the FY 2018 APU, which is associated with patient admissions occurring January 1, 2016 through December 31, 2016).

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

c. Previously Finalized Data Submission Mechanism, Collection Timelines, and Submission Deadlines for the FY 2017 Payment Determination

In the FY 2015 Hospice Wage Index final rule (79 FR 50486), we finalized our policy requiring that, for the FY 2017 reporting requirements, hospices must complete and submit HIS records

for all patient admissions to hospice after July 1, 2014. For each HQRP program year, we require that hospices submit data on each of the adopted measures in accordance with the reporting requirements specified in sections III.E.7c through III.E.7e of that FY 2015 Hospice Wage Index final rule for the designated reporting period. This requirement applies to previously finalized and adopted measures, as well as new measures proposed through the rulemaking process. Electronic submission is required for all HIS records. Although electronic submission of HIS records is required, hospices do not need to have an electronic medical record to complete or submit HIS data. In the FY 2014 Hospice Wage Index final rule (78 FR 48258), we finalized that to complete HIS records, providers can use either the Hospice Abstraction Reporting Tool (HART) software, which is free to download and use, or vendor-designed software. HART provides an alternative option for hospice providers to collect and maintain facility, patient, and HIS Record information for subsequent submission to the QIES ASAP system. Once HIS records are complete, electronic HIS files must be submitted to CMS via the QIES ASAP system. Electronic data submission via the QIES ASAP system is required for all HIS submissions; there are no other data submission methods available. Hospices have 30 days from a patient admission or discharge to submit the appropriate HIS record for that patient through the QIES ASAP system. We will continue to make HIS completion and submission software available to hospices at no cost. We provided details on data collection and submission timing under the downloads section of the HIS Web site on the CMS.gov Web site at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>.

The QIES ASAP system provides reports upon successful submission and processing of the HIS records. The final validation report may serve as evidence of submission. This is the same data submission system used by nursing homes, inpatient rehabilitation facilities, home health agencies, and long-term care hospitals for the submission of Minimum Data Set Version 3.0 (MDS 3.0), Inpatient Rehabilitation Facility-patient assessment instrument (IRF-PAI), Outcome Assessment Information Set (OASIS), and Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LTCH CARE), respectively. We have provided

hospices with information and details about use of the HIS through postings on the HQRP Web site, Open Door Forums, announcements in the CMS MLN Connects Provider e-News (E-News), and provider training.

d. Previously Finalized Data Submission Timelines and Requirements for FY 2018 Payment Determination and Subsequent Years

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

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

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

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

The QIES ASAP system validation edits are designed to monitor the timeliness and ensure that providers' submitted records conform to the HIS data submission specifications. Providers are notified when timing criteria have not been met by warnings that appear on their Final Validation Reports. A standardized data collection approach that coincides with timely submission of data is essential to establish a robust quality reporting program and ensure the scientific reliability of the data received.

In the FY 2016 Hospice Wage Index final rule (80 FR 47191), we clarified the difference between the completion deadlines and the submission deadlines. Current sub-regulatory guidance produced by CMS (for example, HIS Manual, HIS trainings) states that the completion deadlines for HIS records are 14 days from the Event Date for HIS-Admission records and 7 days from the Event Date for HIS-Discharge records. Completion deadlines continue to reflect CMS guidance only; these guidelines are not statutorily specified and are not designated through regulation. These guidelines are intended to offer clear direction to hospice agencies in regards to the timely completion of HIS-Admission and HIS-Discharge records. The completion deadlines define only the latest possible date on which a hospice *should* complete each HIS record. This guidance is meant to better align HIS completion processes with clinical workflow processes; however, hospices may develop alternative internal policies to complete HIS records. Although it is at the discretion of the hospice to develop internal policies for completing HIS records, we continue to recommend that providers complete and attempt to submit HIS records early, prior to the previously finalized submission deadline of 30 days, beginning in FY 2018. Completing and attempting to submit records early allows providers ample time to address any technical issues encountered in the QIES ASAP submission process, such as correcting fatal error messages. Completing and attempting to submit records early will ensure that providers are able to comply with the 30 day submission deadline. HQRPs guidance documents, including the CMS HQRPs Web site, HIS Manual, HIS trainings, Frequently Asked Questions (FAQs), and Fact Sheets continue to offer the most up-to-date CMS guidance to assist providers in the successful completion and submission of HIS records. Availability of updated guidance will be communicated to providers through the usual CMS HQRPs communication channels, including postings and announcements on the CMS HQRPs Web site, MLN eNews communications, National provider association calls, and announcements on Open Door Forums and Special Open Door Forums.

e. Previously Finalized HQRPs Data Submission and Compliance Thresholds for the FY 2018 Payment Determination and Subsequent Years

To accurately analyze quality reporting data received by hospice providers, it is imperative we receive

ongoing and timely submission of all HIS-Admission and HIS-Discharge records. In the FY 2016 Hospice Wage Index final rule (80 FR 47192), we finalized the timeliness criteria for submission of HIS-Admission and HIS-Discharge records in response to input from our stakeholders seeking additional specificity related to HQRPs compliance affecting FY payment determinations and, due to the importance of ensuring the integrity of quality data submitted.

Last year, we finalized our policy (80 FR 47191 through 47192) that beginning with the FY 2018 payment determination and subsequent FY payment determinations, all HIS records would have to be submitted within 30 days of the event date, which is the patient's admission date or discharge date. In conjunction with this requirement, we also finalized our policy (80 FR 47192) to establish an incremental threshold for compliance over a 3 year period. To be compliant for the FY 2018 APU determination, hospices must submit no less than 70 percent of their total number of HIS-Admission and HIS-Discharge records by no later than 30 days from the event date. The timeliness threshold is set at 80 percent for the FY 2019 APU determination and at 90 percent for the FY 2020 APU determination and subsequent years. The threshold corresponds with the overall amount of HIS records received from each provider that fall within the established 30 day submission timeframes. Our ultimate goal is to require all hospices to achieve a compliance rate of 90 percent or more.

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

- Beginning January 1, 2016 to December 31, 2016, hospices must submit at least 70 percent of all required HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2018.
- Beginning January 1, 2017 to December 31, 2017, hospices must submit at least 80 percent of all required HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2019.
- Beginning January 1, 2018 to December 31, 2018, hospices must submit at least 90 percent of all required

HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2020.

Timely submission of data is necessary to accurately analyze quality measure data received by providers. To support the feasibility of a hospice to achieve the compliance thresholds, CMS's measure development contractor conducted some preliminary analysis of Quarter 3 and Quarter 4 HIS data from 2014. According to this analysis, the vast majority of hospices (92 percent) would have met the compliance thresholds at 70 percent. Moreover, 88 percent and 78 percent of hospices would have met the compliance thresholds at 80 percent and 90 percent, respectively. We believe this analysis is further evidence that the compliance thresholds are reasonable and achievable by hospice providers.

The current reports available to providers in the Certification and Survey Provider Enhanced Reports (CASPER) system do allow providers to track the number of HIS records that are submitted within the 30 day submission timeframe. Currently, submitting an HIS record past the 30 day submission timeframe results in a non-fatal (warning) error. In April 2015, we made available 3 new Hospice Reports in CASPER, which include reports that can list HIS Record Errors by Field by Provider and HIS records with a specific error number. We are working on expanding this functionality of CASPER reports to include a timeliness compliance threshold report that providers could run to determine their preliminary compliance with the timeliness compliance requirement. We expect these reports to be available by late spring/early summer of 2016.

In the FY 2016 Hospice Wage Index final rule (80 FR 47192 through 47193), we provided clarification regarding the methodology used in calculating the 70 percent/80 percent/90 percent compliance thresholds. In general, HIS records submitted for patient admissions and discharges occurring during the reporting period (January 1st to December 31st of the reporting year involved) will be included in the denominator for the compliance threshold calculation. The numerator of the compliance threshold calculation would include any records from the denominator that were submitted within the 30 day submission deadline. In the FY 2016 Hospice Wage Index final rule (80 FR 47192), we stated that we would make allowances in the calculation methodology for two (2) circumstances. First, the calculation methodology will

be adjusted following the applicable reporting period for records for which a hospice is granted an extension or exemption by CMS. Second, adjustments will be made for instances of modification/inactivation requests (Item A0050. Type of Record = 2 or 3). Additional helpful resources regarding the timeliness compliance threshold for HIS submissions can be found under the downloads section of the Hospice Item Set Web site at CMS.gov at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>. Lastly, as further details of the data submission and compliance threshold are determined by CMS, we anticipate communicating these details through the regular CMS HQRP communication channels, including postings and announcements on the CMS HQRP Web site, MLN eNews communications, National provider association calls, and announcements on Open Door Forums and Special Open Door Forums.

f. New Data Collection and Submission Mechanisms Under Consideration for Future Years

We have made great progress in implementing the objectives set forth in the quality reporting and data collection activities required by Sections 3004 and 3132 of the Affordable Care Act. To date, we have established the HQRP, which includes 7 NQF-endorsed quality measures that are collected via the HIS. As stated in this rule, data on these measures are expected to be publicly reported sometime in 2017. Additionally, we have implemented the Hospice CAHPS® as part of the HQRP to gather important input on patient experience of care in hospice. Over the past several years, we have conducted data collection and analysis on hospice utilization and trends to help reform the hospice payment system. In the FY 2016 Hospice Wage Index final rule, we finalized payment reform measures, including changes to the RHC payment rate and the implementation of a Service Intensity Add-On (SIA) payment, effective January 1, 2016. As part of payment reform and ongoing program integrity efforts, we will continue ongoing monitoring of utilization trends for any future refinements.

To facilitate continued progress towards the requirements set forth in both sections 3004 and 3132 of the Affordable Care Act, we are considering developing a new data collection mechanism for use by hospices. This new data collection mechanism would be a hospice patient assessment instrument, which would serve 2

primary objectives concordant with the Affordable Care Act legislation: (1) To provide the quality data necessary for HQRP requirements and the current function of the HIS; and (2) provide additional clinical data that could inform future payment refinements.

We believe that the development of a hospice patient assessment tool could offer several benefits over the current mechanisms of data collection for quality and payment purposes, which include the submission of HIS data and the submission of claims data. For future payment refinements, a hospice patient assessment tool would allow us to gather more detailed clinical information, beyond the patient diagnosis and comorbidities that are currently reported on hospice claims. As stated in the FY 2016 Hospice Wage Index final rule (80 FR 47203), detailed patient characteristics are necessary to determine whether a case mix payment system could be achieved. A hospice patient assessment tool would allow us to capture information on symptom burden, functional status, and patient, family, and caregiver preferences, all of which will inform future payment refinements.

While systematic assessment is vital throughout the continuum of care, including palliative and end-of-life care, documentation confirming completion of systematic assessment in hospice settings is often inadequate or absent.²⁶ The value of the introduction of structured approaches via a clinical assessment is well established, as it enables a more comprehensive and consistent way of identifying and meeting patient needs.²⁷

Moreover, symptoms are the leading reason that people seek medical care in the first place and frequently serve as the basis for establishing a diagnosis. Measures of physical function and disease burden have been used to identify older adults at high-risk for excess health care utilization, disability, or mortality.²⁸ Currently, data collected on claims includes line-item visits by discipline, General Inpatient Care (GIP) visit reporting to hospice patients in skilled nursing facilities or hospitals, post-mortem visits, injectable and non-

injectable drugs and infusion pumps. Industry representatives have communicated to us that required claims information is not sufficiently comprehensive to accurately reflect the provision and the cost of hospice care.

For quality data collection, a hospice patient assessment instrument would support the goals of the HQRP as new quality measures are developed and adopted. Since the current quality data collection tool (HIS) is a chart abstraction tool, not a hospice patient assessment instrument, we are limited in the types of data that can be collected via the HIS. Instead of retrospective data collection elements, a hospice patient assessment tool would include data elements designed to be collected concurrent with provision of care. As such, we believe a hospice patient assessment tool would allow for more robust data collection that could inform development of new quality measures that are meaningful to hospice patients, their families and caregivers, and other stakeholders.

Finally, a hospice patient assessment tool that provides clinical data that is used for both payment and quality purposes would align the hospice benefit with other care settings that use similar approaches, such as nursing homes, inpatient rehabilitation facilities, and home health agencies which submit data via the MDS 3.0, IRF-PAI, and OASIS, respectively.

We envision the hospice patient assessment tool itself as an expanded HIS. The hospice patient assessment tool would include current HIS items, as well as additional clinical items that could be used for payment refinement purposes or to develop new quality measures. The hospice patient assessment tool would not replace existing requirements set forth in the Medicare Hospice CoPs (such as the initial nursing and comprehensive assessment), but would be designed to complement data that are collected as part of normal clinical care. If such a patient assessment were adopted, the new data collection effort would replace the current HIS, but would not replace other HQRP data collection efforts (that is, the Hospice CAHPS® survey), nor would it replace regular submission of claims data. We envision that patient assessment data would be collected upon a patient's admission to and discharge from any Medicare-certified hospice provider; additional interim data collection efforts are also possible. If we develop and implement a hospice patient assessment tool, we would provide several training opportunities to ensure providers are able to comply with any new requirements.

²⁶ McMillan, S., Small, B., & Haley, W. (2011). Improving Hospice Outcomes through Systematic Assessment: A Clinical Trial. *Cancer Nursing*, 34(2), 89–97.

²⁷ Bourbonnais, F.F., Perreault, A., & Bouvette, M. (2004). Introduction of a pain and symptom assessment tool in the clinical setting—lessons learned. *Journal of Nursing Management*, 12(3), 194–200.

²⁸ Sha, M., Callahan, C., Counsell, S., Westmoreland, G., Stump, T., Kroenke, K. (2005). Physical symptoms as a predictor of health care use and mortality among older adults. 118, 301–306.

We are not proposing a hospice patient assessment tool at this time; we are still in the early stages of development of an assessment tool to determine if it would be feasible to implement under the Medicare Hospice Benefit. In the development of such a hospice patient assessment tool, we will continue to receive stakeholder input from MedPAC and ongoing input from the provider community, Medicare beneficiaries, and technical experts. It is of the utmost importance to develop a hospice patient assessment tool that is scientifically rigorous and clinically appropriate, thus we believe that continued and transparent involvement of stakeholders is critical. Additionally, it is of the utmost importance to minimize data collection burden on providers; in the development of any hospice patient assessment tool, we will ensure that patient assessment data items are not duplicative or overly burdensome to providers, patients, caregivers, or their families.

We solicit comments on a potential hospice patient assessment tool that would collect both quality, clinical, and other data with the ability to be used to inform future payment refinement efforts.

8. HQRP Submission Exemption and Extension Requirements for the FY 2017 Payment Determination and Subsequent Years

In the FY 2015 Hospice Wage Index final rule (79 FR 50488), we finalized our proposal to allow hospices to request, and for us to grant exemptions/extensions for the reporting of required HIS quality data when there are extraordinary circumstances beyond the control of the provider. When an extension/exemption is granted, a hospice will not incur payment reduction penalties for failure to comply with the requirements of the HQRP. For the FY 2016 payment determination and subsequent payment determinations, a hospice may request an extension/exemption of the requirement to submit quality data for a specified time period. In the event that a hospice requests an extension/exemption for quality reporting purposes, the hospice would submit a written request to CMS. In general, exemptions and extensions will not be granted for hospice vendor issues, fatal error messages preventing record submission, or staff error.

In the event that a hospice seeks to request an exemption or extension for quality reporting purposes, the hospice must request an exemption or extension within 30 days of the date that the extraordinary circumstances occurred by submitting the request to CMS via

email to the HQRP mailbox at HospiceQRPreconsiderations@cms.hhs.gov. Exception or extension requests sent to CMS through any other channel will not be considered valid. The request for an exemption or extension must contain all of the finalized requirements as outlined on our Web site at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Extensions-and-Exemption-Requests.html>.

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

This process does not preclude us from granting extensions/exemptions to hospices that have not requested them when we determine that an extraordinary circumstance, such as an act of nature, affects an entire region or locale. We may grant an extension/exemption to a hospice if we determine that a systemic problem with our data collection systems directly affected the ability of the hospice to submit data. If we make the determination to grant an extension/exemption to hospices in a region or locale, we will communicate this decision through routine CMS HQRP communication channels, including postings and announcements on the CMS HQRP Web site, MLN eNews communications, National provider association calls, and announcements on Open Door Forums and Special Open Door Forums.

9. Hospice CAHPS® Participation Requirements for the 2019 APU and 2020 APU

National Implementation of the Hospice CAHPS® Survey started January 1, 2015 as stated in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452). The CAHPS® Hospice Survey is a component of CMS' Hospice Quality Reporting Program that emphasizes the experiences of hospice patients and their primary caregivers listed in the hospice patients' records. Readers who want more information are referred to our extensive discussion of the Hospice Experience of Care Survey in the

Hospice Wage Index FY 2015 final rule for a description of the measurements involved and their relationship to the statutory requirement for hospice quality reporting (79 FR 50450 and 78 FR 48261).

a. Background and Description of the Survey

The CAHPS® Hospice Survey is the first national hospice experience of care survey that includes standard survey administration protocols that allow for fair comparisons across hospices. Consistent with many other CMS CAHPS® surveys that are publicly reported on CMS Web sites, we will publicly report hospice data when at least 12 months of data are available, so that valid comparisons can be made across hospice providers in the United States, in order to help patients, family, friends, and caregivers choose the right hospice program.

The goals of the CAHPS® Hospice Survey are to:

- Produce comparable data on hospice patients' and caregivers' perspectives of care that allow objective and meaningful comparisons between hospices on domains that are important to consumers.
- Create incentives for hospices to improve their quality of care through public reporting of survey results.
- Hold hospice care providers accountable by informing the public about the providers' quality of care.

Details regarding CAHPS® Hospice Survey national implementation, and survey administration as well as participation requirements, exemptions from the survey requirement, hospice patient and caregiver eligibility criteria, fielding schedules, sampling requirements, and the languages in which is questionnaire, are available on the CAHPS® Web site, www.HospiceCAHPSsurvey.org and in the Quality Assurance Guidelines (QAG) manual, which is also on the same site and is available for download. Measures from the survey will be submitted to the NQF for endorsement.

b. Participation Requirements To Meet Quality Reporting Requirements for the FY 2019 APU

To meet participation requirements for the FY 2019 APU, hospices must collect survey data on an ongoing monthly basis from January 2017 through December 2017 (inclusive). Data submission deadlines for the 2019 APU can be found in Table 17. The data must be submitted by the deadlines listed in Table 17 by the hospice's authorized approved CMS vendor.

Hospices provide lists of the patients who died under their care to form the sample for the Hospice CAHPS® Survey. We emphasize the importance of hospices providing complete and

accurate information to their vendors in a timely manner. Hospices must contract with an approved Hospice CAHPS® Survey vendor to conduct the survey on their behalf. The hospice is

responsible for making sure their vendor meets all data submission deadlines. Vendor failure to submit data on time will be the responsibility of the hospice.

TABLE 17—CAHPS® HOSPICE SURVEY DATA SUBMISSION DATES FY 2018 APU, FY 2019 APU, AND FY 2020 APU

Sample months (that is, month of death) ¹	Quarterly data submission deadlines ²
FY 2018 APU	
January–March 2016 (Q1)	August 10, 2016.
April–June 2016 (Q2)	November 9, 2016.
July–September 2016 (Q3)	February 8, 2017.
October–December 2016 (Q4)	May 10, 2017.
FY 2019 APU	
January–March 2017 (Q1)	August 9, 2017.
April–June 2017 (Q2)	November 8, 2017.
July–September 2017 (Q3)	February 14, 2018.
October–December 2017 (Q4)	May 9, 2018.
FY 2020 APU	
January–March 2018 (Q1)	August 8, 2018.
April–June 2018 (Q2)	November 14, 2018.
July–September 2018 (Q3)	February 13, 2019.
October–December 2018 (Q4)	May 8, 2019.

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 August, November, February, and May.

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

Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2016 through December 31, 2016 are exempt from CAHPS® Hospice Survey data collection and reporting requirements for the FY 2019 payment determination. To qualify, hospices must submit an exemption request form. This form will be available in first quarter 2017 on the CAHPS® Hospice Survey Web site <http://www.hospiceCAHPSsurvey.org>. Hospices that want to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2016 through December 31, 2016. The due date for submitting the exemption request form for the FY 2019 APU is August 10, 2017.

We propose that hospices that received their CCN after January 1, 2017, are exempted from the FY 2019 APU Hospice CAHPS® requirements due to newness. This exemption will be determined by CMS. The exemption is for 1 year only.

c. Participation Requirements To Meet Quality Reporting Requirements for the FY 2020 APU

To meet participation requirements for the FY 2020 APU, hospices must collect survey data on an ongoing monthly basis from January 2018

through December 2018 (inclusive). Data submission deadlines for the 2020 APU can be found in Table 17. The data must be submitted by the deadlines in Table 17 by the hospice’s authorized approved CMS vendor.

Hospices must contract with an approved Hospice CAHPS® survey vendor to conduct the survey on their behalf. The hospice is responsible for making sure their vendor meets all data submission deadlines. Vendor failure to submit data on time will be the responsibility of the hospice.

Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2017 through December 31, 2017 are exempt from CAHPS® Hospice Survey data collection and reporting requirements for the FY 2020 payment determination. To qualify, hospices must submit an exemption request form. This form will be available in first quarter 2018 on the CAHPS® Hospice Survey Web site <http://www.hospiceCAHPSsurvey.org>. Hospices that want to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2017 through December 31, 2017. The due date for submitting the exemption request form for the FY 2020 APU is August 10, 2018.

We propose that hospices that received their CCN after January 1, 2018, are exempted from the FY 2020 APU Hospice CAHPS® requirements due to newness. This exemption will be determined by CMS. The exemption is for 1 year only.

d. Annual Payment Update

The Affordable Care Act requires that beginning with FY 2014 and each subsequent fiscal year, 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 fiscal year, unless covered by specific exemptions. Any such reduction will not be cumulative and will not be taken into account in computing the payment amount for subsequent fiscal years. In the FY 2015 Hospice Wage Index final rule, we added the CAHPS® Hospice Survey to the Hospice Quality Reporting Program requirements for the FY 2017 payment determination and determinations for subsequent years.

- To meet the HQRP requirements for the FY 2018 payment determination, hospices would collect survey data on a monthly basis for the months of January 1, 2016 through December 31, 2016 to qualify for the full APU.

- To meet the HQRP requirements for the FY 2019 payment determination, hospices would collect survey data on a monthly basis for the months of January 1, 2017 through December 31, 2017 to qualify for the full APU.

- To meet the HQRP requirements for the FY 2020 payment determination, hospices would collect survey data on a monthly basis for the months of January 1, 2018 through December 31, 2018 to qualify for the full APU.

e. Hospice CAHPS® Reconsiderations and Appeals Process

Hospices are required to monitor their respective Hospice CAHPS® Survey vendors to ensure that vendors submit their data on time. The hospice CAHPS® data warehouse provides reports to vendors and hospices, including reports on the status of their data submissions. Details about the reports and emails received after data submission should be referred to the Quality Assurance Guidelines Manual. If a hospice does not know how to retrieve their reports, or lacks access to the reports, they should contact Hospice CAHPS® Technical Assistance at hospiceCAHPSsurvey@hcqis.org or call them at 1-844-472-4621. Additional information can be found on page 113 of the Hospice CAHPS® Quality Assurance Guidelines manual Version 2.0 which is available on the Hospice CAHPS® Web site, www.hospicecahpsurvey.org.

In the FY 2017 payment determination and subsequent years, reporting compliance is determined by successfully fulfilling both the Hospice CAHPS® Survey requirements and the HIS data submission requirements. Providers would use the same process for submitting a reconsideration request that are outlined in section III.C.10 of this proposed rule.

10. HQRP Reconsideration and Appeals Procedures for the FY 2017 Payment Determination and Subsequent Years

In the FY 2015 Hospice Wage Index final rule (79 FR 50496), we notified hospice providers on how to seek reconsideration if they received a noncompliance decision for the FY 2016 payment determination and subsequent years. A hospice may request reconsideration of a decision by CMS that the hospice has not met the requirements of the Hospice Quality Reporting Program for a particular period. For the FY 2017 payment determination and subsequent years, reporting compliance is determined by successfully fulfilling both the Hospice CAHPS® Survey requirements and the HIS data submission requirements.

We clarified that any hospice that wishes to submit a reconsideration request must do so by submitting an email to CMS containing all of the requirements listed on the HQRP Web site at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html>. Electronic email sent to HospiceQRPreconsiderations@cms.hhs.gov is the only form of submission that will be accepted. Any reconsideration requests received through any other channel including the United States Postal Service or phone will not be considered as a valid reconsideration request. We codified this process at § 418.312(h). In addition, we codified at § 418.306(b)(2) that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements for that FY and solicited comments on all of the proposals and the associated regulations text at § 418.312 and in § 418.306. Official instructions regarding the payment reduction reconsideration process can be located under the Regulations and Guidance, Transmittals, 2015 Transmittals Web site at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2015-Transmittals-Items/R52QRL.html?DLPage=1&DLEntries=10&DLSort=4&DLSortDir=descending>.

In the past, only hospices found to be non-compliant with the reporting requirements set forth for a given payment determination received a notification from CMS of this finding along with instructions for requesting reconsideration in the form of a United States Postal Service (USPS) letter. In the FY 2016 Hospice Wage Index final rule (80 FR 47198), we proposed to use the QIES CASPER reporting system as an additional mechanism to communicate to hospices regarding their compliance with the reporting requirements for the given reporting cycle. We will implement this additional communication mechanism via the QIES CASPER timeliness compliance reports. As stated in section III.E.7e, of this proposed rule these QIES CASPER reports will be automated reports that hospices will be able to generate at any point in time to determine their *preliminary* compliance with HQRP requirements, specifically, the timeliness compliance threshold for the HIS. We believe the QIES CASPER timeliness compliance reports meet our intent of developing a method to

communicate as quickly, efficiently, and broadly as possible with hospices regarding their *preliminary* compliance with reporting requirements. We will continue to send notification of noncompliance via delivery of a letter via the United States Postal Service. Requesting access to the CMS systems is performed in 2 steps. Details are provided on the QIES Technical Support Office Web site at <https://www.qtso.com/hospice.html>. Providers may access the CMS QIES Hospice Users Guides and Training on the QIES Technical Support Office Web site and selecting Hospice and then selecting the CASPER Reporting Users Guide at <https://www.qtso.com/hospice/train.html>. Additional information about how to access the QIES CASPER reports will be provided prior to the availability of these new reports.

We proposed to disseminate communications regarding the availability of hospice compliance reports in CASPER files through CMS HQRP communication channels, including postings and announcements on the CMS HQRP Web site, MLN eNews communications, National provider association calls, and announcements on Open Door Forums and Special Open Door Forums. We further proposed to publish a list of hospices who successfully meet the reporting requirements for the applicable payment determination on the CMS HQRP Web site <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html>. We proposed updating the list after reconsideration requests are processed on an annual basis. We clarified that the published list of compliant hospices on the CMS HQRP Web site would include limited organizational data, such as the name and location of the hospice. Finalizing the list of compliant providers for any given year is most appropriately done after the final determination of compliance is made. It is our intent for the published list of compliant hospices to be as complete and accurate as possible, giving recognition to all providers who were compliant with HQRP requirements for that year. Finalizing the list after requests for reconsideration are reviewed and a final determination of compliance is made allows for a more complete and accurate listing of compliant providers than developing any such list prior to reconsideration. Developing the list after the final determination of compliance has been made allows providers whose initial determination of noncompliance was

reversed to be included in the list of compliant hospices for that year. We believe that finalizing the list of compliant hospices annually, after the reconsideration period will provide the most accurate listing of hospices compliant with HQRP requirements.

11. 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. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public for the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the CMS Web site.

We recognize that public reporting of quality data is a vital component of a robust quality reporting program and are fully committed to developing the necessary systems for transparent public reporting of hospice quality data. We also recognize that it is essential that the data made available to the public be meaningful and that comparing performance between hospices requires that measures be constructed from data collected in a standardized and uniform manner. Hospices have been required to use a standardized data collection approach (HIS) since July 1, 2014. Data from July 1, 2014 onward is currently being used to establish the scientific soundness of the quality measures prior to the onset of public reporting of the 7 quality measures implemented in the HQRP. We believe it is critical to establish the reliability and validity of the quality measures prior to public reporting to demonstrate the ability of the quality measures to distinguish the quality of services provided. To establish reliability and validity of the quality measures, at least 4 quarters of data will be analyzed. Typically, the first 1 or 2 quarters of data reflect the learning curve of the facilities as they adopt standardized data collection procedures; these data often are not used to establish reliability and validity. We began data collection in CY 2014; the data from CY 2014 for Quarter 3 (Q3) was not used for assessing validity and reliability of the quality measures. We analyzed data collected by hospices during Quarter 4 (Q4) CY 2014 and Q1–Q3 CY 2015. Preliminary analyses of HIS data show that all 7 quality measures that can be calculated using HIS data are eligible for public reporting (NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1641, modified NQF

#1647, NQF #1617). Based on analyses conducted to establish reportability of the measures, 71 percent–90 percent of all hospices would be able to participate in public reporting, depending on the measure. For additional details regarding analysis, we refer readers to the Measure Testing Executive Summary document available on the “Current Measures” section of the CMS HQRP Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>. Although analyses show that many hospices perform well on the 7 measures from the HIS measure set, the measures still show variation, especially among hospices with suboptimal performance, indicating that these measures are still meaningful for comparing quality of care across hospice providers. In addition to conducting quantitative analysis to establish scientific acceptability of the HIS measures, CMS’s measure development contractor, RTI International, also conducted interviews with family and caregivers of hospice patients. The purpose of these interviews was to determine what information patients and caregivers would find useful in selecting hospices, as well as gathering input about patient and caregiver experience with hospice care. Results from these interviews indicate that all 7 HIS quality measures provide consumers with useful information. Interview participants stated that quality measure data would be especially helpful in identifying poor quality outliers that inform beneficiaries, families, caregivers, and other hospice stakeholders.

To inform which of the HIS measures are eligible for public reporting, CMS’s measure development contractor, RTI International, examined 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. This goal of this analysis is to establish the minimum denominator size for public reporting, and is referred to as “reportability” analysis. Reportability analysis is necessary since small denominators may not yield statistically meaningful QM scores. Thus, for other quality reporting programs, such as Nursing Home Compare,²⁹ CMS sets a minimum denominator size for public reporting, as well as the data selection

period necessary to generate the minimum denominator size. Reportability analysis showed that calculating and publicly displaying measures based on 12 months of data would allow for sufficient measure denominator size. Having ample denominator size ensures that quality measure scores that are publicly reported are reliable and stable; a minimum sample size of 20 stays is commonly applied to assessment-based quality measures in other reporting programs. The 12 month data selection period produced significantly larger mean and median sample sizes among hospices, which will generate more reliable quality measure scores. Additionally, our analysis revealed that when applying a minimum sample size of 20 stays, using rolling 12 months of data to create QMs would only exclude about 10 percent – 29 percent of hospices from public reporting, depending on the measure. For more information on analyses conducted to determine minimum denominator size and data selection period, we refer readers to the Reportability Analysis Section of the Measure Testing Executive Summary, available on the “Current Measures” portion of the CMS HQRP Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>.

Based on reportability analysis and input from other stakeholders, we have determined that all 7 HIS measures are eligible for public reporting. Thus, we plan to publicly report all 7 HIS measures on a CMS Compare Web site for hospice agencies. For more details on each of the 7 measures, including information on measure background, justification, measure specifications, and measure calculation algorithms, we refer readers to the HQRP QM User’s Manual v1.00 Final document, which is available on the downloads portion of the Hospice Item Set Web site, CMS HQRP Web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>. Individual scores for each of the 7 HIS measure scores would be reported on a new publicly available CMS Hospice Compare Web site. Current reportability analysis indicates that a minimum denominator size of 20 based on 12 rolling months of data would be sufficient for public reporting of all HIS quality measures. Under this methodology, hospices with a quality measure denominator size of smaller than 20 patient stays would not have the

²⁹ “CMS Nursing Home Quality Initiative—Centers for Medicare* * *” 2011. 25 Jan. 2016, https://www.cms.gov/nursinghomequalityinits/45_nhqmids30trainingmaterials.asp.

quality measure score publicly displayed since a quality measure score on the basis of small denominator size may not be reliable. We will continue to monitor quality measure performance and reportability and will adjust public reporting methodology in the future if needed.

Reportability analysis is typically conducted on a measure-by-measure basis. We would like to clarify that any new measure adopted as part of the HQRP will undergo reportability analysis to determine: (1) if the measure is eligible for public reporting; and (2) the data selection period and minimum denominator size for the measure. Results of reportability analyses conducted for new measures will be communicated through future rulemaking.

In addition, the Affordable Care Act requires that reporting be made public on a CMS Web site and that providers have an opportunity to review their data prior to public reporting. We are currently developing the infrastructure for public reporting, and will provide hospices an opportunity to review their quality measure data prior to publicly reporting information about the quality of care provided by Medicare-certified hospice agencies throughout the nation. These quality measure data reports or "preview reports" will be made available in the CASPER system prior to public reporting and will offer providers the opportunity to review their quality measure data prior to public reporting on the CMS Compare Web site for hospice agencies. Under this process, providers would have the opportunity to review and correct data they submit on all measures that are derived from the HIS. Reports would contain the provider's performance on each measure calculated based on HIS submission to the QIES ASAP system. The data from the HIS submissions would be populated into reports with all data that have been submitted by the provider. We will post preview reports with sufficient time for providers to be able to submit, review data, make corrections to the data, and view their data. Providers are encouraged to regularly evaluate their performance in an effort to ensure the most accurate information regarding their agency is reflected.

We also plan to make available additional provider-level feedback reports, which are separate from public reporting and will be for provider viewing only, for the purposes of internal provider quality improvement. As is common in other quality reporting programs, quality reports would contain feedback on facility-level performance on quality metrics, as well as

benchmarks and thresholds. For the CY 2015 Reporting Cycle, several new quality reporting provider participation reports were made available in CASPER. Providers can access a detailed list and description of each of the 12 reports currently available to hospices on the QIES Web site, under the Training and Education Selections, CASPER Reporting Users Guide at <https://www.qtso.com/hospicetrain.html>. We anticipate that providers would use the quality reports as part of their Quality Assessment and Performance Improvement (QAPI) efforts.

Furthermore, to meet the requirement for making such data public, we are developing a CMS Hospice Compare Web site, which will provide valuable information regarding the quality of care provided by Medicare-certified hospice agencies throughout the nation. Consumers would be able to search for all Medicare approved hospice providers that serve their city or zip code (which would include the quality measures and CAHPS® Hospice Survey results) and then find the agencies offering the types of services they need, along with provider quality information. Based on the efforts necessary to build the infrastructure for public reporting, we anticipate that public reporting of the eligible HIS quality measures on the CMS Compare Web site for hospice agencies will begin sometime in the spring/summer of CY 2017. To help providers prepare for public reporting, we will offer opportunities for stakeholder engagement and education prior to the rollout of a Hospice Compare site. We will offer outreach opportunities for providers through the MLN eNews, Open Door Forums and Special Open Door Forums; we will also post additional educational materials regarding public reporting on the CMS HQRP Web site. Finally, we will offer training to all hospice providers on the systems and processes for reviewing their data prior to public reporting; availability of trainings will be communicated through the regular CMS HQRP communication channels, including postings and announcements on the CMS HQRP Web site, MLN eNews communications, National provider association calls, and announcements on Open Door Forums and Special Open Door Forums.

Like other CMS Compare Web sites, the Hospice Compare Web site will, in time, feature a quality rating system that gives each hospice a rating of between 1 and 5 stars. Hospices will have prepublication access to their own agency's quality data, which enables each agency to know how it is performing before public posting of data

on the Hospice Compare Web site. Public comments regarding how the rating system would determine a hospice's star rating and the methods used for calculations, as well as a proposed timeline for implementation will be announced via regular CMS HQRP communication channels, including postings and announcements on the CMS HQRP Web site, MLN eNews communications, provider association calls, and announcements on Open Door Forums and Special Open Door Forums. We will announce the timeline for development and implementation of the star rating system in future rulemaking.

Lastly, as part of our ongoing efforts to make healthcare more transparent, affordable, and accountable for all hospice stakeholders, the HQRP is prepared to post hospice data on a public data set, the Data.Medicare.gov Web site, and directory located at <https://data.medicare.gov>. This site includes the official datasets used on the Medicare.gov Compare Web sites provided by CMS. In addition, this data will serve as a helpful resource regarding information on Medicare-certified hospice agencies throughout the nation. In an effort to move toward public reporting of hospice data, we will initially post demographic data of hospice agencies that have been registered with Medicare. This list will include addresses, phone numbers, and services provided for each agency. The timeline for posting hospice demographic data on a public dataset is scheduled for sometime late spring/summer CY 2016. Additional details regarding hospice datasets will be announced via regular CMS HQRP communication channels, including postings and announcements on the CMS HQRP Web site, MLN eNews communications, National provider association calls, and announcements on Open Door Forums and Special Open Door Forums. In addition, we will provide the applicable list of CASPER/ ASPEN coordinators in the event the Medicare-certified agency is either not listed in the database or the characteristics/administrative data (name, address, phone number, services, or type of ownership) is incorrect or has changed. To continue to meet Medicare enrollment requirements, all Medicare providers are required to report changes to their information in their enrollment application as outlined in the Provider-Supplier Enrollment Fact Sheet Series located at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/>

[downloads/MedEnroll_InstProv_FactSheet_ICN903783.pdf](#).

D. The Medicare Care Choices Model

The Medicare Care Choices Model (MCCM) offers a new option for Medicare beneficiaries with certain advanced diseases who meet the model's other eligibility criteria to receive hospice-like support services from MCCM participating hospices while receiving care from other Medicare providers for their terminal illness. This 5 year model is being tested to encourage greater and earlier use of the Medicare and Medicaid hospice benefit to determine whether it can improve the quality of life and care received by Medicare beneficiaries, increase beneficiary, family, and caregiver satisfaction, and reduce Medicare or Medicaid expenditures. Participation in the model will be limited to Medicare and dual eligible beneficiaries with advanced cancers, chronic obstructive pulmonary disease (COPD), congestive heart failure, and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome who qualify for the Medicare or Medicaid hospice benefit and meet the eligibility requirements of the model. The model includes over 130 hospices from 39 states across the country and is projected to serve 100,000 beneficiaries by 2020. The first cohort of MCCM participating hospices began providing services under the model in January 2016, and the second cohort will begin to provide services under the model in January 2018. The last patient will be accepted into the model 6 months before the December 31, 2020 model end date.

For more information, see the MCCM Web site: <https://innovation.cms.gov/initiatives/Medicare-Care-Choices/>.

IV. Collection of Information Requirements

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

A. Proposed Information Collection Requirements

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. 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 six NQF endorsed measures and one modified measure 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) (modified).

Data for the aforementioned 7 measures is collected via the HIS. Data collection for the 7 NQF-endorsed measures via the HIS V1.00.0 was approved by the Office of Management and Budget April 3, 2014 (OMB control number 0938-1153—Hospice Quality Reporting Program). As outlined in this proposed rule, we continue data collection for these 7 NQF-endorsed measures.

In this proposed rule, we propose the implementation of two new measures. The first measure is the Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission. Seven individual care processes will be captured in this composite measure, which includes the six NQF-endorsed quality measures and one modified NQF-endorsed quality measure currently implemented in the HQRP. Thus, the Hospice and Palliative Care Composite Process quality measure will use the current HQRP quality measures as its components. The data source for this measure will be currently implemented HIS items that are currently used in the calculation of the seven component measures. Since the proposed measure is a composite measure created from components, which are currently adopted HQRP

measures, no new data collection will be required; data for the composite measure will come from existing items from the existing seven HQRP component measures. We propose to begin calculating this measure using existing data items, beginning April 1, 2017; this means patient admissions occurring on or after April 1, 2017, would be included in the composite measure calculation.

The second measure is the Hospice Visits when Death is Imminent Measure Pair. Data for this measure would be collected via the existing data collection mechanism, the HIS. We proposed that four new items be added to the HIS-Discharge record to collect the necessary data elements for this measure. We expect that data collection for this quality measure via the four new HIS items would begin no earlier than April 1, 2017. Thus, under current CMS timelines, hospice providers would begin data collection for this measure for patient admissions and discharges occurring on or after April 1, 2017.

We proposed the HIS V2.00.0 to fulfill the data collection requirements for the 7 currently adopted NQF measures and the 2 new proposed measures. The HIS V2.00.0 contains:

- All items from the HIS V1.00.0, which are necessary to calculate the 7 adopted NQF measures (and thus the proposed composite measure), plus the HIS V1.00.0 administrative items necessary for patient identification and record matching
- One new item for measure refinement of the existing measure NQF #1637 Pain Assessment.
- New items to collect data for the Hospice Visits when Death is Imminent measure pair.
- New administrative items for patient record matching and future public reporting of hospice quality data.

Hospice providers will submit an HIS-Admission and an HIS-Discharge for each patient admission. Using HIS data for assessments submitted October 1, 2014 through September 30, 2015, we have estimated that there will be approximately 1,248,419 discharges across all hospices per year; therefore, we would expect that there should be 1,248,419 HIS (consisting of one admission and one discharge assessment per patient), submitted across all hospices yearly. Over a 3-year period, we expect 3,745,257 Hospice Item Sets across all hospices. There were 4,259 certified hospices in the United States as of January 2016;³⁰ we estimate that each individual hospice

³⁰ Quality Improvement and Evaluation System (QIES) List of Hospice Providers, January 2016.

will submit on average 293 Hospice Item Sets annually, which is approximately 24 Hospice Items Sets per month or 879 Hospice Item Sets over three years.

The HIS consists of an admission assessment and a discharge assessment. As noted above, we estimate that there will be 1,248,419 hospice admissions across all hospices per year. Therefore, we expect there to be 2,496,838 HIS assessment submissions (admission and discharge assessments counted separately) submitted across all hospices annually, which is 208,070 across all hospices monthly, or 7,490,514 across all hospices over 3 years. We further estimate that there will be 586 Hospice Item Set submissions by each hospice annually, which is approximately 49 submissions monthly or 1,759 submissions over 3 years.

For the Admission Hospice Item Set, we estimate that it will take 14 minutes of time by a clinician such as a Registered Nurse at an hourly wage of \$67.10³¹ to abstract data for Admission Hospice Item Set. This would cost the facility approximately \$15.66 for each admission assessment. We further estimate that it will take 5 minutes of

time by clerical or administrative staff person such as a medical data entry clerk or medical secretary at an hourly wage of \$32.24³² to upload the Hospice Item Set data into the CMS system. This would cost each facility approximately \$2.69 per assessment. For the Discharge Hospice Item Set, we estimate that it will take 9 minutes of time by a clinician, such as a nurse at an hourly wage of \$67.10 to abstract data for Discharge Hospice Item Set. This would cost the facility approximately \$10.07. We further estimate that it will take 5 minutes of time by clerical or administrative staff, such as a medical data entry clerk or medical secretary at an hourly wage of \$32.24 to upload data into the CMS system. This would cost each facility approximately \$2.69. The estimated cost for each full Hospice Item Set submission (admission assessment and discharge assessment) is \$31.10.

We estimate that the total nursing time required for completion of both the admission and discharge assessments is 23 minutes at a rate of \$67.10 per hour. The cost across all Hospices for the nursing/clinical time required to complete both the admission and

discharge Hospice Item sets is estimated to be \$32,111,417 annually, or \$96,334,252 over 3 years, and the cost to each individual Hospice is estimated to be \$7,539.66 annually, or \$22,618.98 over 3 years. The estimated time burden to hospices for a medical data entry clerk to complete the admission and discharge Hospice Item Set assessments is 10 minutes at a rate of \$32.24 per hour. The cost for completion of the both the admission and discharge Hospice Item sets by a medical data entry clerk is estimated to be \$6,708,171 across all Hospices annually, or \$20,124,514 across all Hospices over 3 years, and \$1,575.06 to each Hospice annually, or \$4,725.17 to each Hospice over 3 years.

The total combined time burden for completion of the Admission and Discharge Hospice Item Sets is estimated to be 33 minutes. The total cost across all hospices is estimated to be \$38,819,589 annually or \$116,458,766 over 3 years. For each individual hospice, this cost is estimated to be \$9,114.72 annually or \$27,344.16 over 3 years. See Table 17 for breakdown of burden and cost by assessment form.

TABLE 17—SUMMARY OF BURDEN HOURS AND COSTS

Regulation section(s)	OMB control No.	Number of respondents	Number of responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting (\$)	Total cost (\$)
Hospice Item Set Admission Assessment.	0938–1153	4,259	1,248,419 per year.	0.233 clinician hours; 0.083 clerical hours.	395,333	Clinician at \$67.10 per hour; Clerical staff at \$32.24 per hour.	\$22,900,166
Hospice Item Set Discharge Assessment.	0938–1153	4,259	1,248,419 per year.	0.150 clinician hours; 0.083 clerical hours.	291,298	Clinician at \$67.10 per hour; Clerical staff at \$32.24 per hour.	15,919,423
3-year total	0938–1153	4,259	7,490,514	0.55 hours	2,059,891	Clinician at \$67.10 per hour; Clerical staff at \$32.24 per hour.	116,458,766

C. Submission of PRA-Related Comments

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

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS' Web site at www.cms.hhs.gov/Paperwork@cms.hhs.gov, or call

the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule and identify the rule (CMS–1652–P) the ICR's CFR citation, CMS ID number, and OMB control number.

ICR-related comments are due June 27, 2016.

V. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

We have examined the impacts of this proposed 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

³¹ The adjusted hourly wage of \$67.10 per hour for a Registered Nurse was obtained using the mean hourly wage from the U.S. Bureau of Labor Statistics, \$33.55. This mean hourly wage is adjusted by a factor of 100 percent to include fringe

benefits. See <http://www.bls.gov/oes/current/oes291141.htm>.

³² The adjusted hourly wage of \$32.24 per hour for a Medical Secretary was obtained using the mean hourly wage from the U.S. Bureau of Labor

Statistics, \$16.12. This mean hourly wage is adjusted by a factor of 100 percent to include fringe benefits. See <http://www.bls.gov/oes/current/oes436013.htm>.

the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 1995; Pub. L. 104-4), and the Congressional Review Act (5 U.S.C. 804(2)).

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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This proposed rule has been designated as economically significant under section 3(f)(1) of Executive Order 12866 and thus a major rule under the Congressional Review Act. Accordingly, we have prepared a regulatory impact analysis (RIA) that, to the best of our ability, presents the costs and benefits of the rulemaking. This proposed rule was also reviewed by OMB.

2. Statement of Need

This proposed rule meets the requirements of our regulations at § 418.306(c), which requires annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of Core-Based Statistical Areas (CBSAs), or previously used Metropolitan Statistical Areas (MSAs). This proposed rule would also update payment rates for each of the categories of hospice care described in § 418.302(b) for FY 2017 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). In 2010, the Congress amended section 1814(i)(6) of

the Act with section 3132(a) of the Affordable Care Act. The amendment authorized the Secretary to revise the methodology for determining the payment rates for routine home care and other services included in hospice care, no earlier than October 1, 2013. In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47164), we finalized the creation of 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 days 61 and over of hospice and created a SIA payment, in addition to the per diem rate for the RHC level of care, equal to the CHC hourly payment rate multiplied by the amount of direct patient care provided by an RN or social worker that occurs during the last 7 days of a beneficiary's life, if certain criteria are met. Finally, section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices and this rule discusses changes in the requirements for the hospice quality reporting program in accordance with section 1814(i)(5) of the Act.

3. Overall Impacts

We estimate that the aggregate impact of this proposed rule would be an increase of \$330 million in payments to hospices, resulting from the hospice payment update percentage of 2.0 percent. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2016 to FY 2017. Using the most recent data available at the time of rulemaking, in this case FY 2015 hospice claims data, we apply the current FY 2016 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 2016 payments. Then, using the same FY 2015 data, we apply the proposed FY 2017 wage index and labor-related share values to simulate FY 2017 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.

4. Detailed Economic Analysis

The FY 2017 hospice payment impacts appear in Table 19. We tabulate the resulting payments according to the classifications in Table 19 (for example, facility type, geographic region, facility ownership), and compare the difference between current and proposed payments to determine the overall impact.

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

The third column shows the effect of the annual update to the wage index. This represents the effect of using the proposed FY 2017 hospice wage index. The aggregate impact of this change is zero percent, due to the proposed hospice wage index standardization factor. However, there are distributional effects of the proposed FY 2017 hospice wage index.

The fourth column shows the effect of the proposed hospice payment update percentage for FY 2017. The proposed 2.0 percent hospice payment update percentage for FY 2017 is based on an estimated 2.8 percent inpatient hospital market basket update, reduced by a 0.5 percentage point productivity adjustment and by a 0.3 percentage point adjustment mandated by the Affordable Care Act, and is constant for all providers.

The fifth column shows the effect of all the proposed changes on FY 2017 hospice payments. It is projected that aggregate payments will increase by 2.0 percent, assuming hospices do not change their service and billing practices in response.

As illustrated in Table 19, the combined effects of all the proposals vary by specific types of providers and by location. For example, due to the changes proposed in this rule, the estimated impacts on FY 2017 payments range from a 1.0 percent increase for hospices providing care in the rural West North Central region to a 2.7 percent increase for hospices providing care in the rural Pacific region.

TABLE 19—PROJECTED IMPACT TO HOSPICES FOR FY 2017

	Number of providers	Updated wage data (%)	Proposed hospice payment update (%)	FY 2017 total change (%)
(1)	(2)	(3)	(4)	(5)
All Hospices	4,142	0.0	2.0	2.0
Urban Hospices	3,151	0.0	2.0	2.0
Rural Hospices	991	-0.1	2.0	1.9
Urban Hospices—New England	137	0.4	2.0	2.4
Urban Hospices—Middle Atlantic	252	0.2	2.0	2.2
Urban Hospices—South Atlantic	419	-0.1	2.0	1.9
Urban Hospices—East North Central	396	-0.1	2.0	1.9
Urban Hospices—East South Central	160	-0.1	2.0	1.9
Urban Hospices—West North Central	218	-0.5	2.0	1.5
Urban Hospices—West South Central	610	-0.2	2.0	1.8
Urban Hospices—Mountain	312	-0.3	2.0	1.7
Urban Hospices—Pacific	608	0.6	2.0	2.6
Urban Hospices—Outlying	39	-0.7	2.0	1.3
Rural Hospices—New England	23	-0.4	2.0	1.6
Rural Hospices—Middle Atlantic	41	-0.2	2.0	1.8
Rural Hospices—South Atlantic	136	0.2	2.0	2.2
Rural Hospices—East North Central	139	0.1	2.0	2.1
Rural Hospices—East South Central	129	-0.1	2.0	1.9
Rural Hospices—West North Central	184	-1.0	2.0	1.0
Rural Hospices—West South Central	183	-0.2	2.0	1.8
Rural Hospices—Mountain	106	-0.2	2.0	1.8
Rural Hospices—Pacific	47	0.7	2.0	2.7
Rural Hospices—Outlying	3	-0.1	2.0	1.9
0—3,499 RHC Days (Small)	887	0.0	2.0	2.0
3,500—19,999 RHC Days (Medium)	2,000	0.0	2.0	2.0
20,000+ RHC Days (Large)	1,255	0.0	2.0	2.0
Non-Profit Ownership	1,069	0.1	2.0	2.1
For Profit Ownership	2,523	-0.1	2.0	1.9
Govt Ownership	159	0.5	2.0	2.5
Other Ownership	391	-0.1	2.0	1.9
Freestanding Facility Type	3,151	0.0	2.0	2.0
HHA/Facility-Based Facility Type	991	0.1	2.0	2.1

Source: FY 2015 hospice claims data from the Standard Analytic Files for CY 2014 (as of June 30, 2015) and CY 2015 (as of December 31, 2015).

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.

5. Alternatives Considered

Since the hospice payment update percentage is determined based on statutory requirements, we did not consider not updating hospice payment rates by the payment update percentage. The proposed 2.0 percent hospice payment update percentage for FY 2017 is based on a proposed 2.8 percent inpatient hospital market basket update for FY 2017, reduced by a 0.5 percentage point productivity adjustment and by an additional 0.3 percentage point. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage for that FY. Section 3401(g) of the Affordable Care Act also mandates that, starting

with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. In addition, section 3401(g) of the Affordable Care Act mandates that in FY 2013 through FY 2019, the hospice payment update percentage will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act).

We considered not proposing a hospice wage index standardization factor. However, as discussed in section III.C.1 of this proposed rule, we believe that adopting a hospice wage index standardization factor would provide a

safeguard to the Medicare program, as well as to hospices, because it will mitigate changes in overall hospice expenditures due to annual fluctuations in the hospital wage data from year-to-year by ensuring that hospice wage index updates and revisions are implemented in a budget neutral manner. We estimate that if the hospice wage index standardization factor is not finalized, total payments in a given year would increase or decrease by as much as 0.3 percent or \$50 million.

6. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 20, we have prepared an accounting statement showing the classification of the expenditures

associated with the provisions of this proposed rule. Table 20 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this proposed rule. This estimate is based on the data for 4,067 hospices in our impact analysis file, which was constructed using FY 2015 claims available as of December 31, 2015. All expenditures are classified as transfers to hospices.

TABLE 20—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS, FROM FY 2016 TO FY 2017

[In \$millions]

Category	Transfers
FY 2017 Hospice Wage Index and Payment Rate Update	
Annualized Monetized Transfers. From Whom to Whom?	\$330.* Federal Government to Medicare Hospices.

* The net increase of \$330 million in transfer payments is a result of the 2.0 percent hospice payment update percentage compared to payments in FY 2016.

7. Conclusion

We estimate that aggregate payments to hospices in FY 2017 would increase by \$330 million, or 2.0 percent, compared to payments in FY 2016. We estimate that in FY 2017, hospices in urban and rural areas would experience, on average, a 2.0 percent and a 1.9 percent increase, respectively, in estimated payments compared to FY 2016. Hospices providing services in the urban Pacific and rural Pacific regions would experience the largest estimated increases in payments of 2.6 percent and 2.7 percent, respectively. Hospices serving patients in rural areas in the West North Central region would experience the lowest estimated increase of 1.0 percent in FY 2017 payments.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small

entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than \$7.5 million to \$38.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. HHS’s practice in interpreting the RFA is to consider effects economically “significant” only if they reach a threshold of 3 to 5 percent or more of total revenue or total costs. The effect of the proposed FY 2017 hospice payment update percentage results in an overall increase in estimated hospice payments of 2.0 percent, or \$330 million. Therefore, the Secretary has determined that this proposed rule will not create a significant economic impact on a substantial number of small entities.

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

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2016, that threshold is approximately \$146 million. This proposed rule is not anticipated to have an effect on State, local, or tribal governments, in the aggregate, or on the private sector of \$146 million or more.

VI. Federalism Analysis and Regulations Text

Executive Order 13132, Federalism (August 4, 1999) requires an agency to provide federalism summary impact statement when it promulgates a proposed rule (and subsequent final rule) that has federalism implications and which imposes substantial direct requirement costs on State and local governments which are not required by statute. We have reviewed this proposed rule under these criteria of Executive Order 13132, and have determined that it will not impose substantial direct costs on State or local governments.

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 and Medicaid Services proposes to amend 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 418.312 is amended by adding paragraph (i) to read as follows:

§ 418.312 Data submission requirements under the hospice quality reporting program.

* * * * *

(i) Retention of HQRP Measures Adopted for Previous Payment Determinations. If HQRP measures are re-endorsed by the NQF without substantive changes in specifications, CMS will implement the measure without notice and comment rulemaking.

Dated: April 1, 2016.

Andrew M. Slavitt,
Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: April 14, 2016.

Sylvia M. Burwell,
Secretary, Department of Health and Human Services.

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