

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1692–P]

RIN 0938–AT26

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

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

ACTION: Proposed rule.

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

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 26, 2018.

ADDRESSES: In commenting, please refer to file code CMS–1692–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three 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–1692–P, P.O. Box 8010, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1692–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT:

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

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

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

SUPPLEMENTARY INFORMATION:

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 website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments.

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

I. Executive Summary

A. Purpose

This rule proposes updates to the hospice payment rates for fiscal year (FY) 2019, as required under section 1814(i) of the Social Security Act (the Act). This rule also proposes conforming regulations text changes as a result of section 51006 of the Bipartisan Budget Act of 2018, which amended section 1861(dd)(3)(B) of the Act such that, effective January 1, 2019, physician assistants (PAs) will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. Finally, this rule proposes changes to the hospice quality reporting program (HQRP), consistent with the requirements of section 1814(i)(5) of the Act. In accordance with section 1814(i)(5)(A) of the Act, hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to their payments.

B. Summary of the Major Provisions

Section III.A of this proposed rule describes monitoring activities intended to identify potential impacts related to the hospice reform policies finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule and analyzes current trends in hospice utilization and expenditures.

Section III.B.1 of this proposed rule proposes updates to the hospice wage index with updated wage data and makes the application of the updated wage data budget neutral for all four levels of hospice care. In section III.B.2 of this proposed rule, we discuss the FY 2019 hospice payment update percentage of 1.8 percent. Sections III.B.3 and III.B.4 of this proposed rule update the hospice payment rates and hospice cap amount for FY 2019 by the hospice payment update percentage discussed in section III.B.2 of this proposed rule. We also propose regulations text changes in section III.C and section III.D pertaining to the definition of “attending physician” and “cap period.”

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

C. Summary of Impacts

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

D. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for CMS. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.¹ This initiative is one component of our agency-wide Patients Over Paperwork Initiative,² which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful

¹ Meaningful Measures web page: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html>.

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

Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that fosters operational efficiencies, and will reduce the costs including, collection and reporting burden while producing quality measurement that is more focused on meaningful outcomes.

The Meaningful Measures Framework has the following objectives:

- Address high-impact measure areas that safeguard public health;
- Patient-centered and meaningful to patients;
- Outcome-based where possible;
- Fulfill each program’s statutory requirements;
- Minimize the level of burden for health care providers (for example, through a preference for EHR-based measures where possible, such as electronic clinical quality measures ³);

- Significant opportunity for improvement;
 - Address measure needs for population based payment through alternative payment models; and
 - Align across programs and/or with other payers.
- In order to achieve these objectives, we have identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities as shown in the Table 1 below.

TABLE 1—MEANINGFUL MEASURES

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

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

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

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

E. Advancing Health Information Exchange

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

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

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

standards in the Data Element Library can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA).

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

Most recently, the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, requires HHS to take new steps to enable the electronic sharing of health information ensuring interoperability for providers and settings across the care continuum. Specifically, the Congress directed ONC to “develop or support a trusted exchange framework, including a common agreement among health information networks nationally.” This framework (<https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement>) outlines a common set of principles for trusted exchange and minimum terms and conditions for trusted exchange in order to enable interoperability across disparate health information networks. In another

³ See section VIII.A.8.c. of the preamble of this proposed rule where we seek comment on the

potential future development and adoption of eCQMs.

important provision, the Congress established new authority for HHS to discourage “information blocking”, defined as practices likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information. We invite providers to learn more about these important developments and how they are likely to affect hospices.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes that the impending death of an individual, upon his or her choice, warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define “palliative care” as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice is compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient’s attending physician (if any) and the hospice medical director must certify that the individual is “terminally ill,” as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual’s prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. The regulations at § 418.22(b)(3) require that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Under the Medicare hospice benefit, the election of hospice care is one a patient choice and once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group is essential in the seamless provision of services. These hospice services are provided primarily in the individual’s home. The hospice interdisciplinary group works with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary’s care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

While the goal of hospice care is to allow the beneficiary to remain in his or her home, circumstances during the end of life may necessitate short-term inpatient admission to a hospital, skilled nursing facility (SNF), or hospice facility for necessary pain control or acute or chronic symptom management that cannot be managed in any other setting. These acute hospice care services ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home. Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. Continuous home care may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with our regulations at § 418.204. A minimum of 8 hours of nursing care, or nursing and aide care, must be furnished on a particular day to qualify for the continuous home care rate (§ 418.302(e)(4)).

Hospices are expected to comply with all civil rights laws, including the provision of auxiliary aids and services to ensure effective communication with patients and patient care representatives with disabilities consistent with section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Additionally, they must provide language access for such persons who are limited in English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information

about these requirements may be found at <http://www.hhs.gov/ocr/civilrights>.

B. Services Covered by the Medicare Hospice Benefit

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

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before care is provided by, or under arrangements made by, that hospice program and that the written plan be periodically reviewed by the beneficiary’s attending physician (if any), the hospice medical director, and an interdisciplinary group (described in section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act).

Upon the implementation of the hospice benefit, the Congress also expected hospices to continue to use volunteer services, though these services are not reimbursed by Medicare (see section 1861(dd)(2)(E) of the Act). As stated in the FY 1983 Hospice Wage Index and Rate Update proposed rule (48 FR 38149), the hospice interdisciplinary group should comprise paid hospice employees as well as hospice volunteers, and that “the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary

spirit of hospices.” This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end-of-life care.

C. Medicare Payment for Hospice Care

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

1. Omnibus Budget Reconciliation Act of 1989

Section 6005(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) amended section 1814(i)(1)(C) of the Act and provided changes in the methodology concerning updating the daily payment rates based on the hospital market basket percentage increase applied to the payment rates in effect during the previous federal fiscal year.

2. Balanced Budget Act of 1997

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

3. FY 1998 Hospice Wage Index Final Rule

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

4. FY 2010 Hospice Wage Index Final Rule

The FY 2010 Hospice Wage Index and Rate Update final rule (74 FR 39384) instituted an incremental 7-year phase-out of the BNAF beginning in FY 2010 through FY 2016. The BNAF phase-out reduced the amount of the BNAF increase applied to the hospice wage index value, but was not a reduction in the hospice wage index value itself or in the hospice payment rates.

5. The Affordable Care Act

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

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

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the

Affordable Care Act, requires, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary’s hospice care prior to the 180th-day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, we finalized in the FY 2011 Hospice Wage Index final rule (75 FR 70435) that the 180th-day recertification and subsequent recertifications would correspond to the beneficiary’s third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the 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

In the FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314) we announced that beginning in 2012, the hospice aggregate cap would be calculated using the patient-by-patient proportional methodology, within certain limits. We allowed existing hospices the option of having their cap calculated 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. If a hospice’s total Medicare payments for the cap year exceed the hospice aggregate cap, then the hospice must repay the excess back to Medicare.

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

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50452) finalized a requirement that requires the Notice of Election (NOE) be filed within 5 calendar days after the effective date of hospice election. If the NOE is filed beyond this 5-day period, hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing (79 FR 50474). Similar to the NOE, the claims processing system must be notified of a beneficiary’s discharge from hospice or hospice benefit revocation within 5 calendar days after the effective date of the discharge/revocation (unless the hospice has already filed a final claim) through the submission of a final claim or a Notice of Termination or Revocation (NOTR).

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50479) also finalized a requirement that the

election form include the beneficiary's choice of attending physician and that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians.

Hospice providers are required to begin using a Hospice Experience of Care Survey for informal caregivers of hospice patients as of 2015. The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50496) provided background, eligibility criteria, survey respondents, and implementation of the Hospice Experience of Care Survey for informal caregivers, that hospices are required to use as of 2015.

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

8. IMPACT Act of 2014

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

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

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we created two different payment rates for RHC that resulted in a higher base payment rate for the first 60 days of hospice care and a reduced

base payment rate for subsequent days of hospice care. We also created a Service Intensity Add-on (SIA) payment payable for services during the last 7 days of the beneficiary's life, equal to the CHC hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse (RN) or social worker that occurs during the last 7 days (80 FR 47177).

In addition to the hospice payment reform changes discussed, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47186) implemented changes mandated by the IMPACT Act, in which the cap amount for accounting years that end after September 30, 2016 and before October 1, 2025 is updated by the hospice payment update percentage rather than using the CPI-U. This was applied to the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016. In addition, we finalized a provision to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the fiscal year for FY 2017 and thereafter. Finally, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47144) clarified that hospices must report all diagnoses of the beneficiary on the hospice claim as a part of the ongoing data collection efforts for possible future hospice payment refinements.

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

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52160), we finalized several new policies and requirements related to the HQRP. First, we codified our policy that if the National Quality Forum (NQF) makes non-substantive changes to specifications for HQRP measures as part of the NQF's re-endorsement process, we will continue to utilize the measure in its new endorsed status, without going through new notice-and-comment rulemaking. We will continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures we have adopted for the HQRP; determinations about what constitutes a substantive versus non-substantive change will be made on a measure-by-measure basis. Second, we finalized two new quality measures for the HQRP for the FY 2019 payment determination and subsequent years: Hospice Visits when Death is Imminent Measure Pair and Hospice and Palliative Care Composite Process Measure-

Comprehensive Assessment at Admission (81 FR 52173). The data collection mechanism for both of these measures is the HIS, and the measures are effective April 1, 2017. Regarding the CAHPS® Hospice Survey, we finalized a policy that hospices that receive their CMS Certification Number (CCN) after January 1, 2017 for the FY 2019 Annual Payment Update (APU) and January 1, 2018 for the FY 2020 APU will be exempted from the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) requirements due to newness (81 FR 52182). The exemption is determined by CMS and is for 1 year only.

D. Trends in Medicare Hospice Utilization

Since the implementation of the hospice benefit in 1983, and especially within the last decade, there has been substantial growth in hospice benefit utilization. The number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to nearly 1.5 million in FY 2017. Similarly, Medicare hospice expenditures have risen from \$2.8 billion in FY 2000 to approximately \$17.5 billion in FY 2017. Our Office of the Actuary (OACT) projects that hospice expenditures are expected to continue to increase, by approximately 8 percent annually, reflecting an increase in the number of Medicare beneficiaries, more beneficiary awareness of the Medicare hospice benefit for end-of-life care, and a growing preference for care provided in home and community-based settings.

There have also been changes in the diagnosis patterns among Medicare hospice enrollees. While in 2002, lung cancer was the top principal diagnosis, neurologically based diagnoses have topped the list for the past 5 years. Additionally, in FY 2013, "debility" and "adult failure to thrive" were the first and sixth most common hospice claims-reported diagnoses, respectively, accounting for approximately 14 percent of all diagnoses; however, effective October 1, 2014, these diagnoses are no longer permitted as principal diagnosis codes on hospice claims. As a result of this, the most common hospice claims-reported diagnoses have changed from primarily cancer diagnoses to neurological and organ-based failure diagnoses. The top 20 most frequently hospice claims-reported diagnoses for FY 2017 are in Table 2 below.

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

Rank	ICD-10/reported principal diagnosis	Count	Percentage
1	G30.9 Alzheimer's disease, unspecified	155,066	10
2	J44.9 Chronic obstructive pulmonary disease	77,758	5
3	I50.9 Heart failure, unspecified	69,216	4
4	G31.1 Senile degeneration of brain, not elsewhere classified	66,309	4
5	C34.90 Malignant Neoplasm Of Unsp Part Of Unsp Bronchus Or Lung	53,137	3
6	G20 Parkinson's disease	40,186	3
7	G30.1 Alzheimer's disease with late onset	38,710	2
8	I25.10 Atherosclerotic heart disease of native coronary art without angina pectoris	34,761	2
9	J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation	33,547	2
10	I67.2 Cerebral atherosclerosis	30,146	2
11	C61 Malignant neoplasm of prostate	25,215	2
12	I63.9 Cerebral infarction, unspecified	22,825	1
13	N18.6 End stage renal disease	21,549	1
14	C18.9 Malignant neoplasm of colon, unspecified	21,543	1
15	C25.9 Malignant neoplasm of pancreas, unspecified	20,851	1
16	I51.9 Heart disease, unspecified	18,794	1
17	I11.0 Hypertensive heart disease with heart failure	18,345	1
18	I67.9 Cerebrovascular disease, unspecified	18,234	1
19	I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease.	15,632	1
20	A41.9 Sepsis, unspecified organism	14,012	1

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

Source: FY 2017 hospice claims data from the CCW, accessed and merged with ICD-10 codes on January 10, 2018.

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47201), we clarified that hospices will report *all* diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, effective October 1, 2015. Analysis of FY 2017 hospice claims show that 100 percent of hospices reported more than one diagnosis, 89 percent submitted at least two diagnoses, and 81 percent included at least three diagnoses.

III. Provisions of the Proposed Rule

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

1. Hospice Payment Reform: Research and Analyses

This section of the proposed rule describes current trends in hospice utilization and provider behavior, such as lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending. Utilization data on these metrics were examined to determine the potential impacts related to the hospice reform policies finalized in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), if any. Moreover, in response to Office of Inspector General (OIG) report “Hospice Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care” (OEI-02-10-00491) released in March 2016, which identified the drugs paid for by Part D and provided to beneficiaries during GIP stays, we have

also continued to monitor non-hospice spending during a hospice election as described in this section. Additionally, we have included information on the costs of hospice care using data from the new hospice Medicare cost report, effective for cost reporting periods that began on or after October 1, 2014 (FY 2015). Section 1814(i)(6) of the Act, as amended by section 3132(a)(1)(B) of the Affordable Care Act, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes, including such data sources as the Medicare cost reports. These preliminary analyses may inform future work that could include such refinements to hospice payment rates.

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

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

The number of days that a hospice beneficiary receives care under a

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

We examined length of stay, meaning the number of hospice days during a single hospice election at the date of live discharge or death. We also examined total *lifetime* length of stay, which would include the sum of all days of hospice care across all hospice elections. This would mean if a beneficiary had one hospice election,

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

was discharged alive, and then re-elected the benefit at a later date, the sum of both elections would count towards their lifetime length of stay. In FY 2017, the average length of stay in hospice was 79.7 days and the average lifetime length of stay in hospice was 96.2 days. The average length of stay was 78.1 days in FY 2015, 79.2 days in FY 2016, and 79.7 days in FY 2017. The average lifetime length of stay similarly remained virtually the same between FY 2016 and FY 2017, 96.1 and 96.2 days, respectively.

The median (50th percentile) length of stay in FY 2017 was 18 days. This means that half of hospice beneficiaries received care for fewer than 18 days and half received care for more than 18 days. While the median length of stay has remained relatively constant over the past several years, the average length of stay has increased from year to year.

The Medicare hospice benefit provides four levels of care: Routine home care, general inpatient care, continuous home care, and inpatient respite care. The majority of hospice

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

TABLE 3—SHARE OF HOSPICE DAYS BY LEVEL OF CARE AND SITE OF SERVICE, FOR BENEFICIARIES DISCHARGED ALIVE OR DECEASED IN FY 2017

Level of care	Site of service	Number of hospice days	% of all hospice days
RHC	Home + Hospice Residential Facility	66,320,796	55.75
	SNF/NF	28,656,850	24.09
	Assisted Living Facility	20,299,401	17.06
	Other	1,351,575	1.14
	Total	116,628,622	98.04
GIP	Inpatient Hospital	409,123	0.34
	Inpatient Hospice Facility	1,158,985	0.97
	Skilled Nursing Facility	64,349	0.05
	Other	5,571	0.01
	Total	1,638,028	1.38
CHC	Home + Hospice Residential Facility	199,595	0.17
	SNF/NF	47,098	0.04
	Assisted Living Facility	78,927	0.07
	Other	3,758	0.00
	Total	329,378	0.28
IRC	Inpatient Hospital	32,397	0.03
	Inpatient Hospice Facility	121,597	0.10
	SNF/NF	206,983	0.17
	Other	1,558	0.00
	Total	362,535	0.30
Total		118,958,563	100

Source: Common Working File (CWF) All hospice claims from 2006 to 2017 were included, for beneficiaries whose final claim in FY 2017, according to through date, for a hospice discharge (excluded status code “30”, indicating a continuing patient). Hospice days with invalid or missing site of service HCPCS code are excluded.

In addition to analyzing the hospice average and average lifetime lengths of stay, we examined the average lifetime lengths of stay associated with hospice principal diagnoses by site of service at admission in FY 2017 (see Table 4 below). We limited our analysis to those beneficiaries that were receiving RHC at

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

stay at 177 days in FY 2017. Beneficiaries with Chronic Kidney Disease and cancer had shorter average lifetime lengths of stay, 56.8 and 63 days, respectively. For all diagnoses, the average lifetime length of stay was 113.5 days in FY 2017 when level of care at admission is RHC.

TABLE 4—AVERAGE LIFETIME LENGTH OF STAY BY DIAGNOSIS AND SITE OF SERVICE ON THE DAY OF ADMISSION IN FY 2017, WHEN LEVEL OF CARE AT ADMISSION IS RHC

Primary hospice diagnosis at admission	Home + hospice residential facility		Assisted living facility		SNF + LTC or non-skilled nursing facility		Other*		All sites of service	
	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay
All Diagnoses	582,280	110.59	115,742	162.60	219,063	102.87	47,700	79.33	964,785	113.53
Alzheimer's, Dementia, and Parkinson's ..	75,915	191.29	39,288	204.24	60,895	143.63	6,741	173.29	182,839	177.00
CVA/Stroke	18,514	176.77	9,013	200.25	14,364	142.65	1,730	141.33	43,621	169.19
Cancers	223,000	63.21	12,408	97.53	30,219	62.22	17,916	40.23	283,543	62.92
Chronic Kidney Disease	12,319	60.69	1,436	81.71	5,537	45.09	952	38.90	20,244	56.84
Heart (CHF and Other Heart Disease)	101,059	130.39	22,138	144.68	36,694	87.61	7,596	94.51	167,487	120.96
Lung (COPD and Pneumonias)	57,733	142.60	7,309	152.88	16,286	88.89	3,863	72.27	85,191	131.23
All Other Diagnoses	93,740	110.34	24,150	138.44	55,068	89.83	8,902	67.27	181,860	106.43

Source: Common Working File (CWF) All hospice claims from 2006 to 2017 were included, for beneficiaries whose final claim in FY 2017, according to through date, for a hospice discharge (excluded status code "30", indicating a continuing patient). Diagnosis code and site of service were determined by the first hospice claim for a beneficiary. Diagnosis categories are consistent with those outlined in Abt's 2015 technical report (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/December-2015-Technical-Report.pdf>).

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

As we indicated above, the average lifetime length of stay across all levels of care at admission was 96.2 days in FY 2017. However, the average lifetime length of stay was 113.5 days in FY 2017 when the level of care was RHC at admission (see Table 5 below). This

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

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

TABLE 5—AVERAGE LIFETIME LENGTH OF STAY LEVEL OF CARE TO RHC AT ADMISSION, FY 2016–FY 2017

	FY 2016		FY 2017	
	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay
Any Level of Care at Admission	1,117,643	96.14	1,176,946	96.17
RHC at Admission	909,961	114.02	964,785	113.53

Source: Common Working File (CWF) All hospice claims were included, for beneficiaries whose final claim in FY 2017, according to through date, for a hospice discharge (excluded status code "30", indicating a continuing patient).

Live Discharges

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

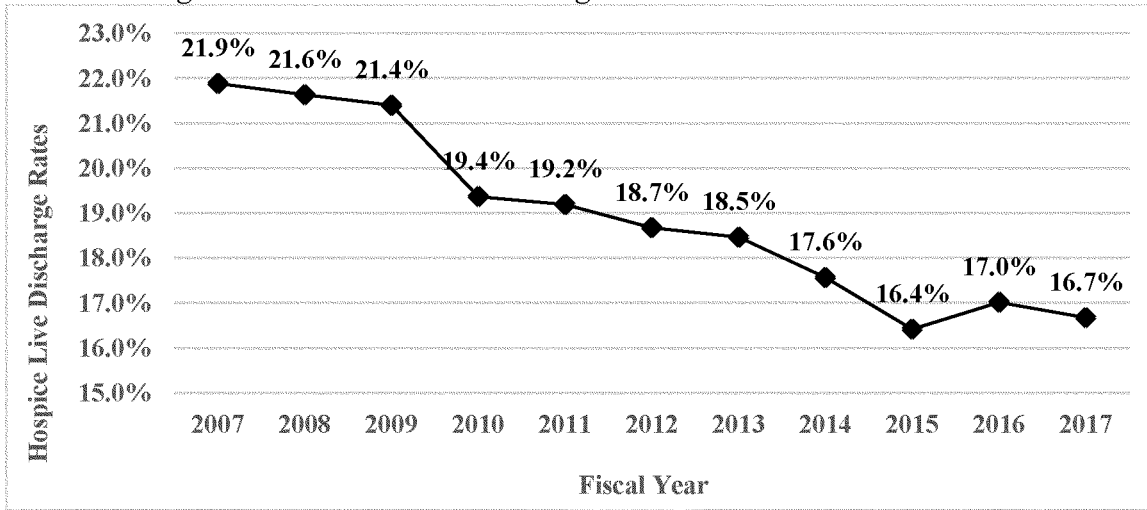
informed choice based on the beneficiary's goals, values and preferences for the services the person wishes to receive through Medicare.

Federal regulations limit the circumstances in which a Medicare hospice provider may discharge a patient from its care. In accordance with § 418.26, discharge from hospice care is permissible when the patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause. Hospices may not discharge the patient at their discretion, even if the care may be costly or inconvenient for the hospice program. As we indicated in the FY 2015 Hospice Wage Index and Payment Rate Update proposed and final rules, we understand that the rate of live discharges should not be zero, given the uncertainties of prognostication and the ability of beneficiaries and their families to revoke the hospice election at any time (79 FR 26549 and 79 FR 50463). On July 1, 2012, we began collecting discharge

information on the claim to capture the reason for all types of discharges which includes, death, revocation, transfer to another hospice, moving out of the hospice's service area, discharge for cause, or due to the beneficiary no longer being considered terminally ill (that is, no longer qualifying for hospice services). In FY 2017, approximately 16.7 percent of hospice beneficiaries were discharged alive (see Figure 1 below). Beneficiary revocations represented 44 percent of all live discharges whereas 45 percent of live discharges were instances where the beneficiary was discharged because the beneficiary was considered no longer terminally ill, and 9 percent of live discharges were instances where beneficiaries transferred to other hospices. In analyzing hospice live discharge rates over time, Figure 1 demonstrates an incremental decrease in average annual rates of live discharge rates from FY 2007 to FY 2015, but an increase in the live discharge rate

between FY 2015 and FY 2016, and a slight decrease between FY 2016 and FY 2017. Between FY 2007 and FY 2017, there has been a reduction in the live discharge rate of 23.7 percent over this time period.

Figure 1: Annual Live Discharge Rates for FY 2007 to FY 2017



Source: FY 2007 through FY 2017 hospice claims data from Common Working File (CWF). All hospice claims were examined that list a discharge status code (meaning claims were excluded if they listed status code 30, indicating a continuing patient). Live discharges were defined as hospice claims with a status code of "01".

As part of our ongoing monitoring efforts, we analyzed the distribution of live discharge rates among hospices with 50 or more discharges (discharged alive or deceased). Table 6 shows that there is significant variation in the rate of live discharge between the 10th and 90th percentiles. Most notably, hospices at the 95th percentile discharged 47.6 percent of their patients alive in FY 2017.

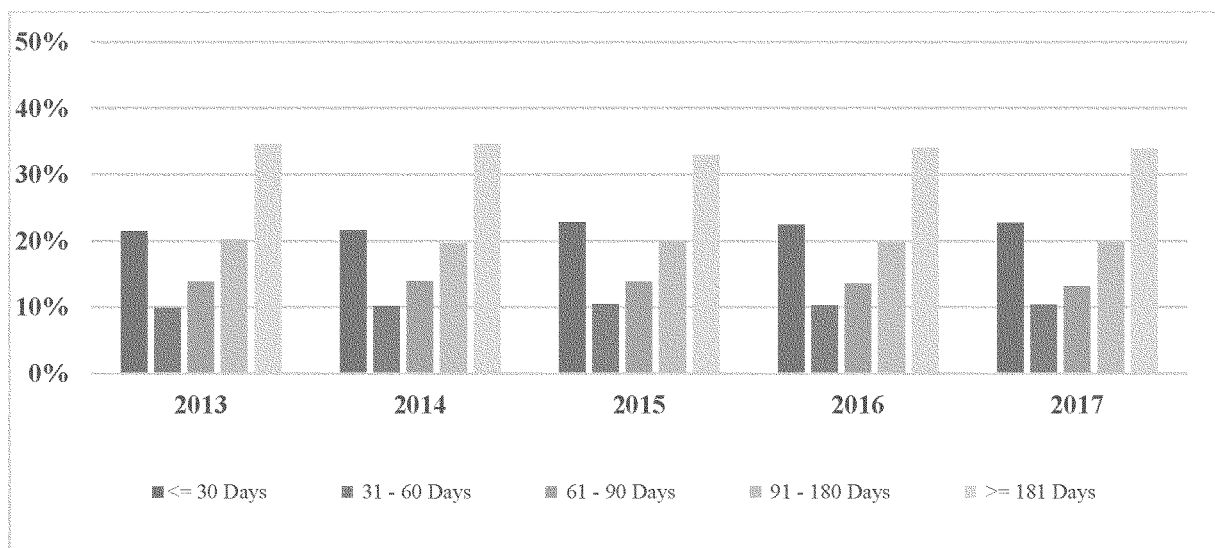
TABLE 6—DISTRIBUTION OF LIVE DISCHARGE RATES FOR HOSPICES WITH 50 OR MORE LIVE DISCHARGES, FY 2015 TO FY 2017

Statistics	Live discharge rate (%)		
	FY 2015	FY 2016	FY 2017
5th Percentile	6.9%	7.0%	6.9%
10th Percentile	8.5%	8.5%	8.4%
25th Percentile	11.6%	11.8%	11.7%
Median	16.8%	17.1%	17.3%
75th Percentile	24.7%	25.6%	25.4%
90th Percentile	35.9%	37.8%	37.3%
95th Percentile	45.6%	49.2%	47.6%
# Providers	3,215	3,268	3,312

Source: FY 2015, FY 2016, and FY 2017 hospice claims data from Common Working File (CWF) that list a discharge status code (meaning claims were excluded if they listed status code 30, indicating a continuing patient). Live discharges were defined as hospice claims with a status code of "01".

Finally, we looked at the distribution of live discharges by length of stay intervals. In looking at the length of stay intervals, 22 percent of the live discharges occurred within 30 days of the start of hospice care, 10 percent between 31 to 60 days, 14 percent between 61 to 90 days, 20 percent between 91 to 180 days, and 35 percent of live discharges occurred after a length of stay over 180 days of hospice care (see Figure 2 below). The proportion of live discharges occurring between the length of stay intervals was relatively constant from FY 2013 to FY 2017. However, we will continue to monitor the data available so as to identify any concerning behavior in response to recent payment policy reforms.

Figure 2. Length of Stay Intervals Distribution for Live Discharges, FY 2013 to FY 2017



Source: FY 2013 – FY 2017 final hospice claims from Common Working File (CWF).

b. Skilled Visits in the Last Days of Life

As we noted in both the FY 2016 and FY 2017 Hospice Wage Index and Rate Update final rules (80 FR 47164 and 81 FR 52143, respectively), we are concerned that many hospice beneficiaries may not be receiving skilled visits during the last days of life. In the period of time immediately preceding death, patient needs typically surge and more intensive services are warranted, so we expect that the provision of care would proportionately escalate in order to meet the increased clinical, emotional, and other needs of the hospice beneficiary and his or her family and caregiver(s). The last week of life is typically the period within the terminal illness trajectory that is associated with the highest symptom burden, typically marked by impactful physical and emotional symptoms, necessitating attentive care and engagement from the integrated hospice team. In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47164 through 47177), the SIA payment policy was finalized with an implementation date of January 1, 2016. This payment was developed in part with the objective of encouraging visits

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

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

shifts in utilization or provision of services to Medicare beneficiaries.

As part of our monitoring efforts, we assessed the delivery of hospice care during the period of time preceding death. Analysis of FY 2017 claims data, which encompasses hospice claims from October 1, 2016 through September 30, 2017, shows that on any given day during the last 7 days of a hospice election, nearly 42 percent of the time the patient has not received a skilled visit (skilled nursing or social worker visit) (see Table 7 below). This figure represents an incremental improvement when compared to the figures presented in our FY 2018 Hospice Wage Index and Rate Update proposed rule (82 FR 20762), where FY 2016 claims showed approximately 44 percent for this metric. Additionally, Table 7 shows that approximately 20 percent of beneficiaries did not receive a skilled visit (skilled nursing or social work visit) on the day of death in FY 2017. This value also indicates an improvement compared to the FY 2016 claims data, in which nearly 21 percent of hospice beneficiaries did not receive a skilled visit on the day of death (82 FR 20762).

TABLE 7—FREQUENCY AND LENGTH OF SKILLED NURSING AND SOCIAL WORK VISITS (COMBINED) DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2017

Visit length	Days before death							All 7 days combined
	0 Days (day of death) (%)	1 Day (%)	2 Days (%)	3 Days (%)	4 Days (%)	5 Days (%)	6 Days (%)	
No Visit	19.9	34.6	42.3	47.7	51.7	55.0	57.4	42.3
15 Minutes to 1 Hour	26.3	31.1	29.0	27.4	26.0	25.0	24.2	27.2
1 Hour, 15 Minutes to 2 Hours	27.3	20.7	18.3	16.4	15.0	13.6	12.8	18.4
2 Hours, 15 Minutes to 3 Hours	13.9	7.4	6.0	5.1	4.4	3.9	3.5	6.8
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	4.9	2.3	1.8	1.4	1.2	1.0	0.9	2.1
4 or More Hours	7.7	3.9	2.6	2.0	1.6	1.3	1.2	3.2

Source: FY 2017 hospice claims data from Common Working File (CWF) (as of January 1, 2018).

While Table 7 above shows the frequency and length of skilled nursing and social work visits combined during the last 7 days of a hospice election in FY 2017, Tables 8 and 9 below show the frequency and length of visits for skilled nursing and social work separately.

Analysis of FY 2017 claims data shows that on any given day during the last 7 days of a hospice election, almost 45 percent of the time the patient had not received a visit by a skilled nurse, and 89 percent of the time the patient had not received a visit by a social worker

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

TABLE 8—FREQUENCY AND LENGTH OF SKILLED NURSING VISITS DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2017

Visit length	Days before death							All 7 days combined
	0 Days (day of death) (%)	1 Day (%)	2 Days (%)	3 Days (%)	4 Days (%)	5 Days (%)	6 Days (%)	
No Visit	21.3	37.3	45.3	50.9	55.0	58.3	60.8	45.1
15 Minutes to 1 Hour	27.3	33.3	30.3	28.1	26.2	24.9	23.9	28.1
1 Hour, 15 Minutes to 2 Hours	27.9	19.6	17.1	15.2	13.8	12.5	11.6	17.6
2 Hours, 15 Minutes to 3 Hours	13.3	5.5	4.3	3.6	3.1	2.7	2.4	5.4
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	4.2	1.6	1.1	0.9	0.8	0.6	0.6	1.5
4 or More Hours	6.1	2.8	1.8	1.4	1.1	0.9	0.8	2.4

Source: FY 2017 hospice claims data from Common Working File (CWF) (as of January 1, 2018).

TABLE 9—FREQUENCY AND LENGTH OF SOCIAL WORK VISITS DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2017

Visit length	Days before death							All 7 days combined
	0 Days (day of death) (%)	1 Day (%)	2 Days (%)	3 Days (%)	4 Days (%)	5 Days (%)	6 Days (%)	
No Visit	89.5	86.5	88.2	89.5	90.2	90.9	91.3	89.3
15 Minutes to 1 Hour	6.6	9.3	8.2	7.4	7.0	6.5	6.2	7.4
1 Hour, 15 Minutes to 2 Hours	2.8	3.5	3.0	2.7	2.5	2.2	2.1	2.8
2 Hours, 15 Minutes to 3 Hours	0.7	0.5	0.4	0.3	0.3	0.3	0.2	0.4
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	0.2	0.1	0.1	0.0	0.0	0.0	0.0	0.1
4 or More Hours	0.2	0.1	0.1	0.0	0.0	0.0	0.0	0.1

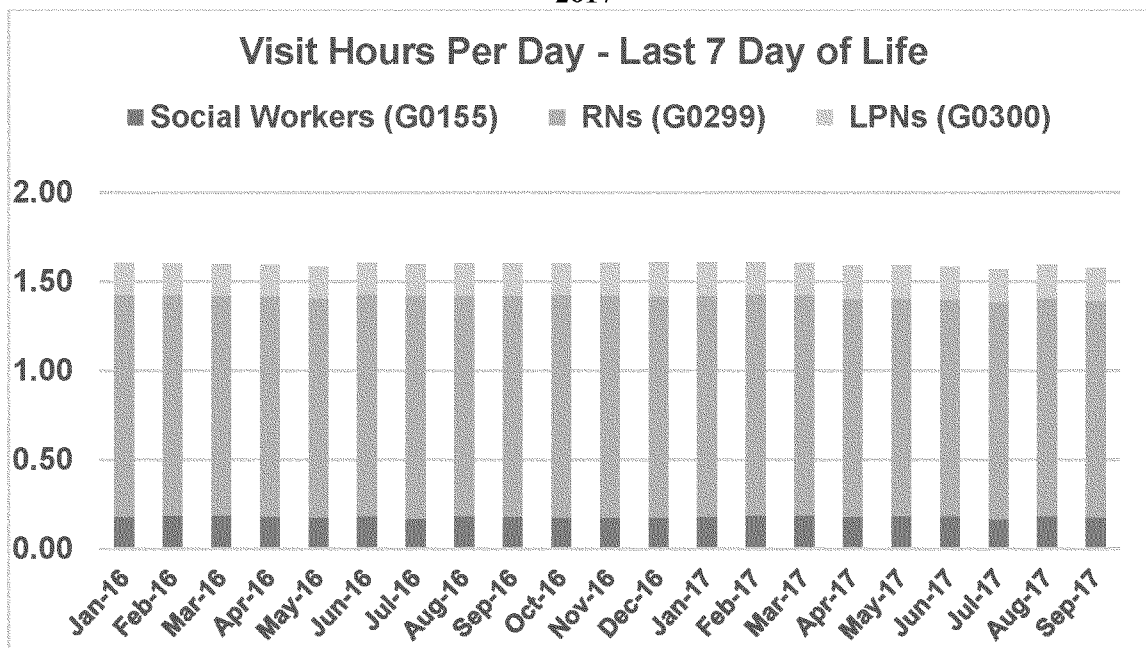
Source: FY 2017 hospice claims data from Common Working File (CWF) (as of January 1, 2018).

Additionally, we have analyzed the overall levels of nursing and medical social services provided during the 7 days prior to death. In an assessment of FY 2015 claims, we estimate that the total number of hours of skilled services, including skilled nursing (as reported with code G0154) and medical social services visits, provided to Medicare hospice beneficiaries in the RHC level of care in the 7 days preceding death was approximately 1.6 hours per day. As depicted in Figure 3 below, from our analysis of FY 2016 and

2017 hospice claims data that begins January 1, 2016 and spans through September 30, 2017, a relatively consistent level of nursing and medical social services visits are being provided among RHC days in the 7 days prior to death, averaging around 1.6 hours per day. For the period spanning January 1, 2016 through September 30, 2017, our analysis shows that approximately 1.24 hours of services were provided by RNs, 0.18 hours were provided by Licensed Practical Nurses (LPNs), and 0.18 hours were provided by social workers per

day. We note that for purposes of the SIA payment, only those hours of service provided by an RN, which became separately categorized as G0299 beginning January 1, 2016, and medical social worker count toward the calculation of the SIA payment. Additionally, we note that G0154 was retired as of January 1, 2016; however, this code was still reported by some providers in the months of January and February 2016, and thus was included in Figure 3.

Figure 3: Visit Hours per Day in the Last Seven Days of Life, January 2016 to September 2017



Source: Medicare hospice claims, January 1, 2016 through September 30, 2017; RHC days only; claims extracted on January 5, 2018 from Common Working File (CWF).

Given this evaluation of this more comprehensive dataset, which encompasses the payment policy changes that began on January 1, 2016, we are concerned at the lack of increase in visits to hospice patients at the end of life. Beneficiaries appear to be receiving similar levels of care when compared to time periods prior to the implementation of the payment policy reforms, which may indicate that hospices are not providing additional resources to patients during a time of increased need. We expect that hospices would be increasing visit frequency at the end of life, as the SIA payment serves to compensate providers for the cost of providing additional, more intensive care at the end of life, in addition to the payment already made

for those RHC level of care days that qualify for the SIA.

Moreover, as described in the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52173), our quality reporting program started data collection effective April 1, 2017 for the quality measure pair, Hospice Visits When Death is Imminent, via the implementation of the new Hospice Item Set (HIS) V2.00. This measure pair assesses hospice staff visits to patients at the end of life. Measure 1 assesses the percentage of patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life while Measure 2 measures the percentage of patients receiving at least two visits from medical social workers, chaplains or spiritual counselors, LPNs,

or hospice aides in the last 7 days of life. Data collected on these measures for the time period of 2017 will be applied to the Hospice Quality Reporting Program's Annual Payment Update (APU) in FY 2019, impacting provider payment based on quality of hospice care provided to Medicare beneficiaries. We will continue to monitor the provision of hospice services at end-of-life and impacts of the SIA payment and other policies.

c. Non-Hospice Spending

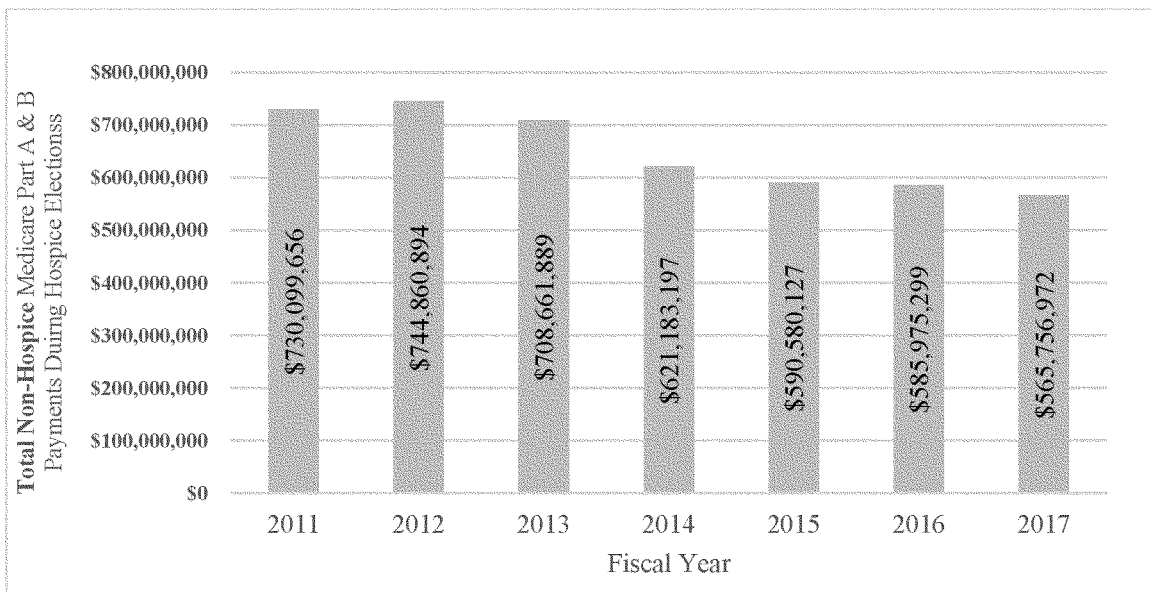
When a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made, except for services

provided by the designated hospice and the attending physician. Hospice services are comprehensive and we have reiterated since 1983 that “virtually all” care needed by the terminally ill individual would be provided by hospice. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life. However, we continue to conduct ongoing analysis of non-hospice spending during a hospice election and the results of our analysis seems to suggest the unbundling of items and services that perhaps should have been provided and covered under the Medicare hospice benefit.

We first reported findings on 2012 non-hospice spending during a hospice election in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452). This proposed rule updates our analysis of non-hospice spending during a hospice election using FY 2017 data. We found that in FY 2017, Medicare paid over \$900 million for items and services under Parts A, B, and D for beneficiaries during a hospice election. Medicare payments for non-hospice Part A and Part B items and services received by hospice beneficiaries during hospice election were \$730 million in FY 2011, \$745 million in FY 2012, \$709 million in FY 2013, \$621 million in FY 2014,

\$591 million in FY 2015, \$586 million in FY 2016, and \$566 million in FY 2017 (see Figure 4 below). The beneficiary cost sharing amount in FY 2017 was \$138 million. Non-hospice spending for Part A and Part B items and services has decreased each year since we began reporting these findings. Overall, from FY 2011 to FY 2017 non-hospice Medicare spending for Parts A and B during hospice election declined 23 percent. However, there continues to be a non-trivial amount of non-hospice Parts A and B spending on beneficiaries under a hospice election, and we will continue to monitor data regarding this issue.

Figure 4: Medicare Payments for Non-Hospice Medicare Part A and Part B items and services during Hospice Elections, FY 2011 – FY 2017



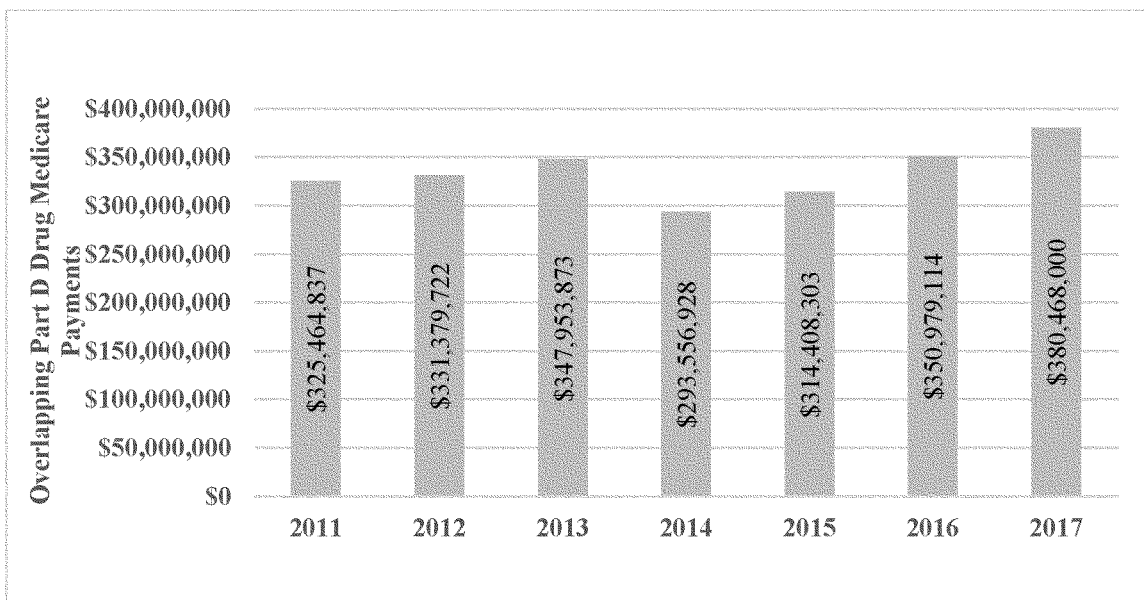
Source: Analysis of 100 percent Medicare Part A and Part B claims data from Common Working File (CWF) (final action claims), FY 2011 through FY 2017, excluding utilization on hospice admission or live discharge days.

We also examined Part D spending from FY 2011 to FY 2017 for those beneficiaries under a hospice election. The data shows Medicare payments for non-hospice Part D drugs received by hospice beneficiaries during a hospice election were \$325 million in FY 2011, \$331 million in FY 2012, \$348 million in FY 2013, \$294 million in FY 2014, \$314 million in FY 2015, \$351 million in FY 2016, and \$380 million in FY 2017 (see Figure 5). In contrast to non-hospice spending during a hospice election for Medicare Parts A and B items and services, non-hospice spending for Part D drugs increased in FY 2017 compared to FY 2011.

Recent analyses of Part D prescription drug event (PDE) data suggest that the current prior authorization (PA) has reduced Part D program payments for drugs in four targeted categories (analgesics, anti-nauseants, anti-anxiety, and laxatives). However, under Medicare Part D there has been an increase in hospice beneficiaries filling prescriptions for a separate category of drugs we refer to as maintenance drugs, as recently analyzed by CMS (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf>). Currently, maintenance drugs for beneficiaries under a hospice election are not subject to the Part D PA

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

Figure 5: Medicare Payments for Non-Hospice Medicare Part D Prescription Drugs during Hospice Elections, FY 2011 - FY 2017



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

Table 10 below details the various components of Part D spending for patients receiving hospice care for FY 2017. The portion of the \$474.2 million total Part D spending that was paid by Medicare is the sum of the Low Income Cost-Sharing Subsidy (row 2 in Table 10) and the Covered Drug Plan Paid Amount (row 5), or approximately \$380.5 million. The beneficiary cost sharing amount was approximately \$68.6 million, including patient pay amount (row 1), other true out-of-pocket amount (row 3), and patient liability reduction due to other payer amount (row 4).

TABLE 10—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES’ FY 2017 DRUGS RECEIVED THROUGH PART D

Component	FY 2017 expenditures
Patient Pay Amount	\$50,903,365
Low Income Cost-Sharing Subsidy	111,159,483
Other True Out-of-Pocket Amount	1,555,456
Patient Liability Reduction due to Other Payer Amount	16,153,569
Covered Drug Plan Paid Amount	269,308,517
Non-Covered Plan Paid Amount	8,664,146
Six Payment Amount Totals	457,744,535
Unknown/Unreconciled	16,425,792

TABLE 10—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES’ FY 2017 DRUGS RECEIVED THROUGH PART D—Continued

Component	FY 2017 expenditures
Gross Total Drug Costs, Reported	474,170,328

Source: Analysis of 100% FY 2017 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) website at: <http://www.resdac.org/>.

Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and related conditions while the patient is under hospice care. For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment unrelated to the terminal illness or related conditions. As noted above, after a hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, those same drugs may be appropriate to continue as they may offer symptom relief for the palliation and management of the terminal prognosis.⁵ In our ongoing analysis of non-hospice spending, we remain

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

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

We continue to expect that hospices should be providing virtually all of the care needed by terminally ill individuals, including related prescription drugs. The comprehensive nature of the services covered under the Medicare hospice benefit is structured such that hospice beneficiaries should not have to routinely seek items, services, and/or medications beyond those provided by hospice. The hospice medical director, the attending physician (if any), and the hospice interdisciplinary group (IDG) determine, on a case-by-case basis, what items and services are related and unrelated to the palliation and management of the terminal illness and related conditions during the admission process, the initial and comprehensive assessments, and in

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

the development of the hospice plan of care (§§ 418.25, 418.54, and 418.56).

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

2. Initial Analysis of Revised Hospice Cost Report Data

a. Background

As mentioned in section II.B of this proposed rule, the Medicare hospice per diem payment amounts were developed to cover all services needed for the palliation and management of the terminal illness and related conditions, as described in section 1861(dd)(1) of the Act. Services provided under a

written plan of care could include: Nursing care provided by or under the supervision of a registered professional nurse; physical therapy, occupational therapy, speech-language pathology services; counseling (including dietary counseling); medical social services under the direction of a physician; services of a home health aide; homemaker services; medical supplies (including drugs and biologicals) and the use of durable medical equipment; physician services; short-term inpatient care (including both respite care and care necessary for pain control and acute and chronic symptom management) in a qualified inpatient facility; or any other item or service which has been specified in the plan of care for which payment may be made under Medicare. Under the current payment system, hospices are paid for each day that a beneficiary is enrolled in hospice care, regardless of whether services are rendered on any given day.

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

b. Methodology

Section 1814(i)(6) of the Act, as amended by section 3132(a)(1)(B) of the Affordable Care Act, authorized the Secretary to collect additional data and information determined appropriate to

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

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

revise payments for hospice care and other purposes. The data collected may be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care. Effective October 1, 2014, we finalized changes to the hospice cost report to improve data collection on the costs of providing hospice care. We conducted an updated analysis of the revised cost report data (CMS Form 1984-14) for freestanding hospices with cost reporting periods in FY 2016, which totaled 2,867 reports. Using this data we calculated preliminary estimates of total costs per day by level of care. It is important to note that the values we computed for cost per day include all payer sources, both Medicare and non-Medicare; however, we believe that the total cost figures represent a reasonable proxy for estimating costs related to the provision of care for Medicare beneficiaries. In order to compute total Medicare-related costs by level of care, we multiplied the computed cost per day by level of care (as reported on Worksheet C) for each hospice by the number of Medicare days by level of care. We then calculated total payments by level of care for each hospice by multiplying the FY 2016 Medicare hospice payments by level of care by the number of Medicare days by level of care. Total costs, payments, and days by level of care were summed for each unique hospice. In order to more accurately account for the hourly CHC cost per day, we used data from Medicare claims in order to quantify the hours of CHC provided by summing the values reported in revenue center 0652, which tallies the units of CHC care. We then divided the CHC costs by the number of CHC hours as reported in revenue center 0652 to calculate a CHC per-hour value. Additionally, we obtained hospice provider characteristics from the Provider of Services (POS) file from December 2016; from that dataset, 4,367 unique providers were identified.

In order to evaluate the cost report data for implausible cost reports or cost reports that included unexpected data values, we applied three distinct trimming methodologies. The first trim applied a simple truncation at the statistical ends of the data. For each calculated outcome (for example, total RHC costs per day), we excluded those values that are above the 99th percentile and those values that are below the 1st percentile. For the purposes of this discussion, we refer to this trim as the "1% Trim."

The second trim is a more robust trim meant to remove unexpected results from the cost report data. For the

purposes of this discussion, we refer to this trim as the “CMS Trim.” The following list shows the exclusion criteria used for this trimming approach. For each element we have listed the number of hospices impacted by each exclusion criteria with the notation “n=XX”. Additionally, we note that an individual hospice’s cost report may have been impacted by multiple exclusion criteria.

1. We exclude cost reports less than 10 months or more than 14 months in length (n=130).
2. We excluded hospices with missing payment (n=2) or cost information (n=0).
3. We excluded hospices with negative payment (n=0) or cost information (n=21).
4. We exclude hospices that are in the 1st or 99th percentile of cost per day (n=60). Cost is determined from Worksheet F-2—Row 41—Column 2 (Total operating expenses). Days are determined from Worksheet S-1—Row 34—Column 4 (Total unduplicated days). Note that these values compute cost per day including all payer sources.
5. We exclude hospices that are in the top and bottom 5 percent of hospices in terms of margins (n=290). Margins were computed including all payer sources.

Cost is determined from Worksheet F-2—Row 41—Column 2 (Total operating expenses). Payments come from worksheet F-2—Row 26—Column 4 (Total Revenues).

6. We exclude hospices that have extreme payment or cost values (n=108). This trimming criterion included agencies where the log of the ratio of payment to cost exceeded the 90th percentile of its distribution plus 1.5 times the interdecile range or if it was less than the 10th percentile minus 1.5 times its interdecile range.

In order to improve the quality of data submitted on the cost report, industry representatives suggested various edits, which, for the purposes of this discussion will be labeled “Level 1 Edits” as they would cause the hospice cost report to be revised before being accepted by the Medicare Administrative Contractors (MACs). These types of edits could force adherence to certain cost reporting principles and could lead to the reporting of higher-quality hospice cost data. The suggested edits would cause Worksheet A to generate a Level 1 Edit and reject a cost report if no costs were included in the following recommended Cost Centers:

- Line 3—Employee Benefits
- Line 4—Administrative and General
- Line 5—Plant Operations and Maintenance
- Line 13—Volunteer Services Coordination
- Line 14—Pharmacy
- Line 28—Registered Nurse
- Line 37—Hospice Aide and Homemaker Services
- Line 38—Durable Medical Equipment/Oxygen
- Line 41—Labs and Diagnostics
- Line 1—Capital Related Costs—Building and Fixtures and
- Line 33—Medical Social Services

In order to estimate the potential impact of the application of these possible edits, we analyzed the 2016 hospice cost report data and applied the edits to the cost centers highlighted by industry representatives and removed cost reports where data was not submitted for the lines of interest. For each of the cost centers identified, we excluded those cost reports that provided no cost data on the line items. In total, almost 66 percent of the cost reports submitted by hospices for 2016 were missing data on one of the reporting lines identified as essential.

TABLE 11—NUMBER AND PERCENTAGE OF FREESTANDING HOSPICE COST REPORTS WITH MISSING INFORMATION IN WORKSHEET A—COLUMN 7—“LEVEL 1 EDITS”

Part of the cost report	Line	% missing	N that are missing
Employee Benefits	3	13.80	385
Administrative & General	4	0.29	8
Plant Operations and Maintenance	5	45.16	1,260
Volunteer Services Coordination	13	37.71	1,052
Pharmacy	14	12.47	348
Registered Nurse	28	1.22	34
Hospice Aide and Homemaker Services	37	2.69	75
Durable Medical Equipment/Oxygen	38	11.65	325
Labs Diagnostics	41	22.83	637
Capital Related Costs—Building and Fixtures	1	17.13	478
Medical Social Services	33	4.37	122
Missing Any of the Above		65.59	1,830

Source: Medicare hospice cost report data for FY 2016.

Given the high volume of cost reports that show zero costs on lines that are expected to be populated, it is evident that hospices may not be providing thorough and representative cost data currently. If we were to implement the industry-requested Level 1 edits to the 2016 cost reports, nearly two thirds of the reports would be rejected based on missing cost data. Given that these edits are for consideration only and have not yet been proposed, we plan to continue collaborating with the provider

community to identify ways in which we may foster the submission of high quality hospice cost data. We reiterate that this “Potential Level 1 Edit” approach is for discussion purposes only and may be considered for potential future use.

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

For the purposes of evaluating calculated costs per day by level of care compared to Medicare payment

amounts, we compared the reported costs on the Medicare cost report to the FY 2016 per diem payment rates by level of care. In order to estimate the potential impact of the application of the three different trim methodologies mentioned above, we analyzed the 2016 hospice cost report data and applied the three sets of edits. Table 12 below shows the distribution of the calculated Average Cost Per Day by Level of Care, using data from Worksheet C—Rows 3, 8, 13, 18—Column 3.

TABLE 12—TOTAL COST PER DIEM BY LEVEL OF CARE APPLYING THREE TRIM METHODOLOGIES

Level of care	Number of cost reports	Mean	Weighted mean	Minimum value	25th percentile	Median	75th percentile	Maximum value	FY 2016 per diem payment amounts
CHC:									
1% Trim	1,171	78	51	2	19	51	90	1,576	* \$944.79
CMS Trim	1,111	135	52	0	18	51	91	19,864	
Level 1 Edits	425	129	53	0	23	52	86	19,864	
RHC:									
1% Trim	2,715	133	125	64	107	127	151	315	161.89
CMS Trim	2,465	148	124	6	106	126	149	19,372	
Level 1 Edits	967	139	123	1	105	125	145	3,487	
IRC:									
1% Trim	1,987	498	397	52	215	313	483	6,678	167.45
CMS Trim	1,828	629	448	2	214	311	489	67,766	
Level 1 Edits	800	602	415	2	215	299	492	25,817	
GIP:									
1% Trim	1,794	1,040	841	75	586	856	1,187	10,370	720.11
CMS Trim	1,664	1,353	834	2	590	858	1,192	149,422	
Level 1 Edits	737	1,287	880	19	596	835	1,094	60,779	

* \$39.37/hr.

Source: Medicare hospice cost report & claims data for FY 2016.

Note: Weighted means are computed based on the number of days by level of care.

As described above, the cost report data analyzed were trimmed to minimize the effect of statistical anomalies. Nevertheless, there is substantial variation in the reported cost per day by hospices under each of the three trimming methodologies. The results displayed in Table 12 indicate that applying the 1% Trim leads to the exclusion of the least number of cost reports, while applying Level 1 Edits leads to the exclusion of the largest number of cost reports. For instance, when total RHC costs per day are trimmed based on the 1% Trim, 2,715 cost reports are retained. Applying the CMS Trim slightly reduces the number of cost reports to 2,465, while applying Level 1 Edits reduces the sample to 967 reports. However, we note that reductions in sample size do not necessarily lead to the exclusion of the largest outliers. For instance, the maximum value for total RHC costs per day is \$315 after the 1% Trim, the analogous value after the CMS Trim is \$19,372, and the analogous value after Level 1 Edits is \$3,487. For mean values, we calculated both unweighted means as well as the means that are weighted by the number of days by level of care. Weighted means are closer to the medians than unweighted means, suggesting that extreme values come from smaller hospices with fewer hospices days. The estimated median cost values are lower than the base payment rate for RHC, but not for CHC, IRC, or GIP.

Total cost per day values in the four levels of care span from a minimum of \$1 to maximum values in the tens of thousands. Because of this wide range of

values in the distribution, we used the median as well as the mean values weighted by the number of days by level of care as reference points in these preliminary analyses. When compared with the FY 2016 per diem payment rates, the calculated median and weighted mean costs associated with providing RHC are lower than the base payment rates. As noted in section III.A of this proposed rule, the RHC level of care accounts for over 98 percent of all hospice days based on our analysis of claims for FY 2017. The median and weighted mean costs for the provision of RHC under all three trim methodologies cluster around an estimated \$126 and \$124 respectively, with both figures presenting lower values than the single RHC FY 2016 per diem payment rate of \$161.89, a difference of approximately \$38 and \$38 respectively.

Conversely, for CHC the estimated median and weighted mean costs per day under each of the three trim methodologies hover around \$51 and 52 per hour, respectively. The FY 2016 payment rate for CHC was \$39.37 per hour. The CHC level of care accounts for approximately 0.28 percent of all hospice days in FY 2017, as noted in section III.A of this proposed rule. Similarly, the median and weighted mean costs per day associated with the provision of GIP care under all three trim methodologies is estimated in the mid-\$800 range, while the FY 2016 per diem payment amount for GIP was \$720.11. As noted in section III.A of this proposed rule, the GIP level of care accounts for approximately 1.38 percent of all hospice days based on our analysis of FY 2017 claims. Likewise,

costs per day associated with the IRC level of care are estimated at around \$300 for median values and in a range of \$397 to nearly \$450 under the three trimming methodologies for weighted mean values. We note that the per diem payment amount for the IRC level of care for FY 2015 was \$167.45, showing a gap between the estimated costs and current payment rate. We estimate that IRC days represent approximately 0.30 percent of all hospice days in FY 2017 claims as described in section III.A of this proposed rule.

As we continue to gather more cost report data, we plan to conduct more thorough analyses of the cost report data and fully assess Medicare-related hospice costs as compared with Medicare hospice payments by level of care. We encourage hospices to continue to submit the most accurate data possible on Medicare cost reports and invite feedback regarding potential edits and other strategies for improving the data for hospice providers.

B. Proposed FY 2019 Hospice Wage Index and Rate Update

1. Proposed FY 2019 Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospice agencies under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished. The hospice wage index utilizes the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Our regulations at § 418.306(c) require each

labor market to be established using the most current hospital wage data available, including any changes made by Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions.

We use the previous FY's hospital wage index data to calculate the hospice wage index values. For FY 2019, the hospice wage index will be based on the FY 2018 hospital pre-floor, pre-reclassified wage index. This means that the hospital wage data used for the hospice wage index are not adjusted to take into account any geographic reclassification of hospitals including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the Core-Based Statistical Areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2019, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia.

There exist some geographic areas where there were no hospitals, and thus, no hospital wage data on which to base the calculation of the hospice wage index. In the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term "contiguous" means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce

a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2019, we propose to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. Pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15 which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

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

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

The proposed hospice wage index applicable for FY 2019 (October 1, 2018

through September 30, 2019) is available on our website at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html>.

2. Proposed FY 2019 Hospice Payment Update Percentage

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

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

The proposed hospice payment update percentage for FY 2019 is based on the estimated inpatient hospital market basket update of 2.9 percent (based on IHS Global Inc.'s first quarter 2018 forecast with historical data through the fourth quarter 2017). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the estimated inpatient hospital market basket update for FY 2019 of 2.9 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.8 percentage point for FY 2019). The estimated inpatient hospital market basket update for FY 2019 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 2019 is 1.8 percent.

Currently, the labor portion of the hospice payment rates is as follows: For RHC, 68.71 percent; for CHC, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. Therefore, the non-labor portion of the payment rates is as follows: For RHC, 31.29 percent; for CHC, 31.29 percent; for General Inpatient Care, 35.99 percent; and for Respite Care, 45.87 percent. Beginning with cost reporting periods starting on or after October 1, 2014, freestanding hospice providers are required to submit cost data using CMS Form 1984–14 (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospice-2014.html>). We are currently analyzing this data for possible use in updating the labor portion of the hospice payment rates. Any changes to the labor portions would be proposed in future rulemaking and would be subject to public comments.

3. Proposed FY 2019 Hospice Payment Rates

There are four payment categories that are distinguished by the location and intensity of the services provided. The base payments are adjusted for geographic differences in wages by

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

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

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47177), we will continue to make the SIA payments budget neutral

through an annual determination of the SIA budget neutrality factor (SBNF), which will then be applied to the RHC payment rates. The SBNF will be calculated for each FY using the most current and complete utilization data available at the time of rulemaking. For FY 2018, we calculated the SBNF using FY 2017 utilization data. For FY 2019, the SBNF that would apply to days 1 through 60 is calculated to be 0.9991. The SBNF that would apply to days 61 and beyond is calculated to be 0.9998.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. In order to calculate the wage index standardization factor, we simulate total payments using the FY 2019 hospice wage index and compare it to our simulation of total payments using the FY 2018 hospice wage index. By dividing payments for each level of care using the FY 2019 wage index by payments for each level of care using the FY 2018 wage index, we obtain a wage index standardization factor for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP). The wage index standardization factors for each level of care are shown in the tables below.

The proposed FY 2019 RHC rates are shown in Table 13. The proposed FY 2019 payment rates for CHC, IRC, and GIP are shown in Table 14.

TABLE 13—PROPOSED FY 2019 HOSPICE RHC PAYMENT RATES

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

TABLE 14—PROPOSED FY 2019 HOSPICE CHC, IRC, AND GIP PAYMENT RATES

Code	Description	FY 2018 payment rates	Wage index standardization factor	Proposed FY 2019 hospice payment update	Proposed FY 2019 payment rates	
652	Continuous Home Care Full Rate = 24 hours of care \$41.62 = hourly rate	\$976.42		× 1.0048	× 1.018	\$998.77
655	Inpatient Respite Care	172.78		× 1.0007	× 1.018	176.01
656	General Inpatient Care	743.55		× 1.0015	× 1.018	758.07

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

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

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

implemented a Hospice Quality Reporting Program (HQRP) as required by section 3004 of the 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

2019 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2019 hospice payment update percentage of 1.8 percent minus 2 percentage points. These rates are shown in Tables 15 and 16.

TABLE 15—PROPOSED FY 2019 HOSPICE RHC PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

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

TABLE 16—PROPOSED FY 2019 HOSPICE CHC, IRC, AND GIP PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2018 payment rates	Wage index standardization factor	Proposed FY 2019 hospice payment update of 1.8% minus 2 percentage points = -0.2%	Proposed FY 2019 payment rates
652	Continuous Home Care	\$976.42	× 1.0048	× 0.998	\$979.14
	Full Rate= 24 hours of care \$40.80 = hourly rate				
655	Inpatient Respite Care	172.78	× 1.0007	× 0.998	172.56
656	General Inpatient Care	743.55	× 1.0015	× 0.998	743.18

4. Proposed Hospice Cap Amount for FY 2019

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (P. L. 113–185). Specifically, for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. The proposed hospice cap amount for the 2019 cap year will be \$29,205.44, which is equal to the 2018 cap amount (\$28,689.04) updated by the proposed FY 2019 hospice payment update percentage of 1.8 percent.

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

In the FY 2018 Hospice Wage Index and Rate Update proposed rule (82 FR 20789), we invited public comments to start a national conversation about improvements that can be made to the

health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families. We specifically stated that we would not respond to the comment submissions in the final rule. Instead, we would review the submitted request for information comments and actively consider them as we develop future regulatory proposals or future sub-regulatory policy guidance.

After reviewing all submitted requests for information, we believe one recommendation in particular warranted a revision to our current policy. Commenters suggested that CMS remove the requirement to report detailed drug data on the hospice claim as a way to reduce burden for hospices. We initially began asking for this information via Hospice Change Request 8358 in support of hospice payment reform [<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Transmittals-Items/Hospice-CR8358-R2747CP.html>]. After determining that this information is not currently used for quality, payment, or

program integrity purposes, we are removing this requirement effective October 1, 2018. We also believe this could result in a significant reduction of burden to Medicare hospices, potentially reducing the number of line items on hospice claims by approximately 21.5 million, in aggregate. We will allow hospices two options for reporting hospice drug information. Providers will have the option to continue to report infusion pumps and drugs, with corresponding NDC information, on the hospice claim as separate line items. This submission option will no longer be mandatory. Alternatively, hospices can submit total, aggregate DME and drug charges on the claim. We believe that removing the requirement for the separate submission of detailed drug information on hospice claim lines and offering the alternative option to submit aggregate, total charge amounts provides flexibility for hospices as well as potentially reducing burden. In order to effectuate this change, we will issue a detailed sub-

regulatory change request, effective October 1, 2018.

Another suggestion which we would like to highlight was for CMS to remove the sequential billing requirement, which requires that claims are submitted in chronological order. While we are always evaluating ways to make operational improvements, sequential billing for hospice claims is required because of how hospice benefit periods are constructed in statute. Specifically, section 1812(a)(4) of the Social Security Act creates a sequence of benefit periods, defining coverage for periods of “hospice care with respect to the individual during up to two benefit periods of 90 days each and an unlimited number of *subsequent* periods of 60 days each . . .”

Sequential billing ensures that Medicare systems create and exhaust each period before creating a later period, maintaining the statutorily-required sequence. In addition, as finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142), payment for routine home care now varies depending on length of stay (a higher rate for days 1–60 and a lower rate for days 61+) making the sequential billing of hospice claims necessary to accurately pay claims and ensure the system applies benefit periods. Sequential billing ensures correct payments are made and to providers, minimizes the need to resubmit claims or face claims denials, and ultimately reduces burden. As a result, we are not able to eliminate the sequential billing requirement for hospice claims.

While we are not proposing changes to either the hospice billing procedures or payment regulations in this proposed rule, we will consider whether future regulatory or sub-regulatory changes are warranted to reduce unnecessary burden. We thank the commenters for taking the time to convey their thoughts and suggestions on this initiative.

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

When electing the Medicare hospice benefit, the beneficiary agrees to forgo the right to have Medicare payment made for services related to the beneficiary’s terminal illness and related conditions, except when such services are provided by the designated hospice and the beneficiary’s designated attending physician as outlined in section 1812(d)(2)(A) of the Act. The designated attending physician plays an important role in the care of a Medicare hospice beneficiary. If a beneficiary designates an attending physician, the beneficiary or his or her representative

acknowledges that the identified attending physician was his or her choice and that the attending physician identified by the beneficiary, at the time he or she elects to receive hospice care, has the most significant role in the determination and delivery of the individual’s medical care. The designated attending physician is required to certify that the beneficiary is terminally ill and participates as a member of the hospice IDG that establishes and/or updates the individual’s plan of care, ensuring that the Medicare beneficiary receives high quality hospice care.

Under the current hospice regulations at 42 CFR 418.3, the attending physician is defined as a doctor of medicine or osteopathy who is legally authorized to practice medicine or surgery by the state in which he or she performs that function, or a nurse practitioner, and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual’s medical care. A nurse practitioner is defined as a registered nurse who performs such services as legally authorized to perform (in the state in which the services are performed) in accordance with state law (or state regulatory mechanism provided by state law) and who meets training, education, and experience requirements described in 42 CFR 410.75.

Section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) amended section 1861(dd)(3)(B) of the Social Security Act such that, effective January 1, 2019, physician assistants (PAs) will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. We define the PA as a professional who has graduated from an accredited physician assistant educational program who performs such services as he or she is legally authorized to perform (in the state in which the services are performed) in accordance with state law (or state regulatory mechanism provided by state law) and who meets the training, education, and experience requirements as the Secretary may prescribe. The PA qualifications for eligibility for furnishing services under the Medicare program can be found in the regulations at 42 CFR 410.74(c). We note section 1861(s)(2)(K)(i) of the Act states that PAs are authorized to furnish physician services under their State scope of practice, under the general supervision of a physician; therefore the regulations at 42 CFR 410.150(a)(15) require that payment for PA services may be made to the employer or contractor of a PA.

Effective January 1, 2019, Medicare will pay for medically reasonable and necessary services provided by PAs to Medicare beneficiaries who have elected the hospice benefit and who have selected a PA as their attending physician. PAs are paid 85 percent of the fee schedule amount for their services as designated attending physicians. Attending physician services provided by PAs may be separately billed to Medicare only if the PA is the beneficiary’s designated attending physician, services are medically reasonable and necessary, services would normally be performed by a physician in the absence of the PA, whether or not the PA is directly employed by the hospice, and services are not related to the certification of terminal illness.

Since PAs are not physicians, as defined in 1861(r)(1) of the Act, they may not act as medical directors or physicians of the hospice or certify the beneficiary’s terminal illness and hospices may not contract with a PA for their attending physician services as described in section 1861(dd)(2)(B)(i)(III) of the Act, which outlines the requirements of the interdisciplinary group as including at least one physician, employed by or under contract with the agency or organization. All of these provisions apply to PAs without regard to whether they are hospice employees.

Finally, we note that the Bipartisan Budget Act of 2018 did not make changes to which practitioners can certify terminal illness for a Medicare beneficiary nor who may perform the face-to-face encounter. Section 1814(a)(7)(A)(i)(I) of the Act was amended by section 51006 of the Bipartisan Budget Act of 2018 to specify that certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or physician member of the IDG and the individual’s attending physician, if he or she has one (except for the purposes of certifying terminal illness the individual’s attending physician does not include a nurse practitioner *or a physician assistant* [emphasis added]), regarding the normal course of the individual’s illness. No one other than a medical doctor or doctor of osteopathy can certify or re-certify terminal illness. PAs were not authorized by section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) to perform the required hospice face-to-face encounter for recertifications. The hospice face-to-face encounter is required per section 1814(a)(7)(D)(i) of the Act, which continues to state that only a hospice

physician or a hospice nurse practitioner can perform the encounter. The regulations at 42 CFR 418.22 will continue to state that the hospice face-to-face encounter must be performed by a hospice physician or hospice nurse practitioner.

In summary, we propose to make statutorily-required updates to § 418.3 in the Hospice Care regulations to expand the definition of attending physician to include physician assistants (PA). We also propose to amend 42 CFR 418.304 (Payment for physician and nurse practitioner services) in the Hospice Care regulations to include the details outlined above regarding Medicare payment for designated hospice attending physician services provided by physician assistants. We are soliciting comments on these proposed changes to the regulations at §§ 418.3 and 418.304.

E. Proposed Technical Correction Regarding Hospice Cap Period Definition

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), we finalized aligning the cap period, for both the inpatient cap and the hospice aggregate cap, with the federal FY for FY 2017 and later. Therefore, the cap year now begins October 1 and ends on September 30 (80 FR 47186). We propose to make a technical correction in § 418.3 to reflect the revised timeframes for hospice cap periods. Specifically, we propose that 42 CFR 418.3 would specify that the cap period means the twelve-month period ending September 30 used in the application of the cap on overall hospice reimbursement specified in § 418.309. We are soliciting comments on this technical change to our regulations at § 418.3.

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

1. Background and Statutory Authority

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

less than 0 percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the particular year involved. Any such reduction would not be cumulative nor be taken into account in computing the payment amount for subsequent FYs. Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form, manner, and at a time specified by the Secretary.

2. General Considerations Used for Selection of Quality Measures for the Hospice QRP

a. Background

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

b. Accounting for Social Risk Factors in the Hospice QRP

In the FY 2018 Hospice Wage Index final rule (82 FR 36652 through 36654), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level, as set out annually in HHS guidelines, <https://www.federalregister.gov/documents/2018/01/18/2018-00814/annual-update-of-the-hhs-poverty-guidelines>, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.⁹

⁹ See, for example United States Department of Health and Human Services. “Healthy People 2020: Disparities. 2014.” Available at: <http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>; or National Academies

Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients as well as those with social risk factors receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in CMS value-based purchasing programs.¹⁰ As we noted in the FY 2018 Hospice Wage Index final rule (82 FR 36652 through 36654), ASPE’s report to Congress, which was required by section 2(d) of the IMPACT Act, found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. ASPE is continuing to examine this issue in its second report required by the IMPACT Act, which is due to Congress in the fall of 2019. In addition, as we noted in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38428), the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.¹¹ The trial period ended in April 2017 and a final report is available at: http://www.qualityforum.org/SES_Trial_Period.aspx. The trial concluded that “measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship” between social risk factors and the outcomes measured. This discrepancy may be explained in part by the “methods used for adjustment and the limited availability of robust data on social risk factors”. NQF has extended the socioeconomic status (SES) trial,¹² allowing further examination of social risk factors in outcome measures.

In the FY 2018/CY 2018 proposed rules for our quality reporting and

of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

¹⁰ Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), “Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs.” December 2016. Available at: <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>.

¹¹ Available at: http://www.qualityforum.org/SES_Trial_Period.aspx.

¹² Available at: <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86357>.

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

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

As a next step, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details, where we discuss the potential stratification of certain Hospital Inpatient Quality Reporting Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to

identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

c. New Measure Removal Factor

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

As we discussed in the Executive Summary, we are engaging in efforts to ensure that the HQRP measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. We believe these costs are multi-faceted and includes not only the burden associated with reporting, but also the costs associated with complying with the program. We have identified several different types of costs, including, but not limited to: (1) Provider and clinician information collection burden and burden associated with the submitting/reporting of quality measures to CMS; (2) the provider and clinician cost associated with complying with other Hospital IQR programmatic requirements; (3) the provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs; (4) the cost to CMS associated with the program oversight of the measure including measure maintenance and public display; and/or (5) the provider and clinician cost associated with compliance to other federal and/or state regulations (depending upon the measure). For example, it may be needlessly costly and/or of limited benefit to retain or maintain a measure for which our analyses show no longer meaningfully supports program objectives (for example, informing beneficiary choice or payment scoring). It may also be costly for health care providers to track the confidential feedback and preview reports, as well as publicly reported information on a measure we use in more than one program. We may also have to expend unnecessary resources to maintain the specifications for the measure, including the tools we need to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs. There also may be other burdens associated

with a measure that arise on a case-by-case basis.

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

We are proposing that we would remove measures based on this factor on a case-by-case basis. We might, for example, decide to retain a measure that is burdensome for health care providers to report if we conclude that the benefit to beneficiaries justifies the reporting burden. Our goal is to move the program forward in the least burdensome manner possible, while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients.

We are inviting public comment on our proposal to adopt an additional measure removal factor, “the costs associated with a measure outweighs the benefit of its continued use in the program,” beginning with the FY 2019 Hospice Wage Index final rule.

3. Previously Adopted Quality Measures for FY 2019 Payment Determination and Future Years

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

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

We finalized the following 2 additional measures in the FY 2017 Hospice Wage Index final rule, effective

April 1, 2017. Data collected will, if not reported, affect payments for FY 2019 and subsequent years. (81 FR 52163 through 52173):

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

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

and successfully received NQF endorsement in July 2017.

Data for the Hospice Visits when Death is Imminent measure pair is being collected using new items added to the HIS V2.00.0, effective April 1, 2017. We will need at least 4 quarters of reliable data to conduct the necessary analyses to support submission to NQF. We will also need to assess the quality of data submitted in the first quarter of item implementation to determine whether they can be used in the analyses. We have begun analysis of the data, and, pending analysis, we will submit the Hospice Visits when Death is Imminent measure pair to NQF for endorsement review in accordance with NQF project timelines and call for measures. We will

use a similar process to analyze and submit new quality measures to NQF for endorsement in future years. Providers will be notified of measure endorsement and the public reporting through sub-regulatory channels.

In the FY 2015 Hospice Wage Index final rule (79 FR 50491 through 50496), we also finalized the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey to support quality measures based on patient and family experience of care. We refer readers to section III.D.5 of the FY 2019 Proposed Rule for details regarding the CAHPS® Hospice Survey, including public reporting of selected survey measures.

TABLE 17—PREVIOUSLY FINALIZED QUALITY MEASURES AFFECTING THE FY 2019 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

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

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

a. Background

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

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

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

designated reporting period. Electronic submission is required for all HIS records. For more information about HIS data collection and submission policies and procedures, we refer readers to the FY 2018 Hospice Wage Index final rule (82 FR 36663) and the CMS HQRP website: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>. For more information about CAHPS® Hospice Survey data submission policies and timelines, we refer readers to section III.D.5 of the FY 2019 proposed rule.

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

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

distinct period of time to review and correct the data that is to be publically reported. This approach would allow hospices a time frame in which they may analyze their data and make corrections (up until 11:59:59 p.m. PST of the quarterly deadline) prior to receiving their preview reports. Once the preview reports are received, it is infeasible to make corrections to the data underlying the quality measure scores that are to be made public. Therefore, we are proposing that for data reported using the HIS that there be a specified time period for data review and a correlating data correction deadline for public reporting at which point the data is frozen for the associated quarter. Similar to the policies outlined in the FY 2016 SNF final rule (81 FR 24271) and the FY 2016 IPPS/LTCH final rule (80 FR 49754), at this deadline for public reporting, we propose that data from HIS records with target dates within the correlating quarter become a frozen “snapshot” of data for public reporting purposes. Any record-level data correction after the date on which the data are frozen will not be incorporated into measure calculation for the

purposes of public reporting on the CMS Hospice Compare website. For each calendar quarter of data submitted using the HIS, approximately 4.5 months after the end of each CY quarter we are proposing a deadline, or freeze date for the submissions of corrections to records. We note that this newly proposed data correction deadline for HIS records is separate and apart from the established 30-day data submission deadline. More information about the data submission deadline can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/>.

Specifically, each deadline would occur on the 15th of the CY month that is approximately 4.5 months after the end of each CY quarter, and that hospices would have up until 11:59:59 p.m. PST on that date to submit corrections or requests for inactivation of their data for the quarter involved. For example, for data reported in CY Q1, the freeze date would be August 15th, for CY Q2 the freeze date would be November 15th and so on. Under this policy, any modification to or inactivation of records that occur after the proposed correction deadline would not be reflected in publicly reported data on the CMS Hospice Compare website. For example, for the data collected during the 1st quarter, that is January 1st through March 31st of a given year, the hospice will have until 11:59:59 p.m. PST on August 15th of that year to ensure all of their data is correct. Any modifications to first quarter data that are submitted to us after August 15th would not be reflected during any subsequent Hospice Compare refresh. We believe that this is a reasonable amount of time to allow providers to make any necessary corrections to submitted data prior to public reporting. This revised policy aligns HQRP with the policies and procedures that exist in our other quality reporting programs including the post-acute care programs, which also enables providers to review their data and make necessary corrections within the specified time frame of approximately 4.5 months following the end of a given CY quarter and prior to the public reporting of such data.

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

We also propose that for the purposes of public reporting, the first quarterly freeze date for CY 2019 data corrections will be August 15, 2019. To accommodate those HIS records with target dates prior to January 1, 2019 and still within a target period for public reporting, we also propose to extend to hospices the opportunity to review their data and submit corrections up until the CY 19 Q1 deadline of 11:59:59 p.m. PST on August 15, 2019. Table 18 presents the proposed data correction deadlines for public reporting beginning in CY 2019.

TABLE 18—DATA CORRECTION DEADLINES FOR PUBLIC REPORTING BEGINNING CY 2019

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

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

We are soliciting public comments on these proposals.

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

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

a. Background and Description of the CAHPS® Hospice Survey

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

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

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

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

b. Overview of the CAHPS® Hospice Survey Measures

The CAHPS® Hospice Survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver (usually a family member) regarding the patient and family experience of care, unlike the Hospital CAHPS® Survey deployed in 2006 (71 FR 48037 through 48039) and other subsequent CAHPS® surveys. National implementation of the CAHPS® Hospice Survey commenced January 1, 2015 as stated in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452).

The survey consists of 47 questions and is available (using the mailed version) in English, Spanish, Chinese, Russian, Portuguese, Vietnamese, Polish, and Korean. It covers topics such as access to care, communications, getting help for symptoms, and interactions with hospice staff. The survey also contains 2 global rating questions and asks for self-reported demographic information (race/ethnicity, educational attainment level, languages spoken at home, among others). The CAHPS® Hospice Survey

measures received NQF endorsement on October 26th, 2016 (NQF #2651). Measures derived from the CAHPS® Hospice Survey include 6 multi-item (composite) measures and 2 global ratings measures. They received NQF endorsement on October 26, 2016 (NQF #2651). We adopted these 8 survey-based measures for the CY 2018 data collection period and for subsequent years. These 8 measures are reported on Hospice Compare.

c. Data Sources

As discussed in the CAHPS® Hospice Survey QAG V4.0 (<http://www.hospiceCAHPSsurvey.org/en/quality-assurance-guidelines/>), the survey has three administration methods: mail only, telephone only, and mixed mode (mail with telephone follow-up of non-respondents). We previously finalized the participation requirements for the FY 2020, FY 2021, and FY 2022 APUs (82 FR 36673). We propose to extend the same participation requirements to all future years, for example, the FY 2023, FY 2024 and FY 2025 Annual Payment and subsequent updates. To summarize, to meet the CAHPS® Hospice Survey requirements for the HQRP, we propose that hospice facilities must contract with a CMS-approved vendor to collect survey data for eligible patients on a monthly basis and report that data to CMS on the hospice’s behalf by the quarterly deadlines established for each data collection period. The list of approved vendors is available at: <http://www.hospiceCAHPSsurvey.org/en/approved-vendor-list>.

Hospices are required to provide lists of the patients who died under their care, along with the associated primary caregiver information, to their respective survey vendors to form the samples for the CAHPS® Hospice Survey. We emphasize the importance of hospices providing complete and accurate information to their respective survey vendors in a timely manner.

Hospices must contract with an approved CAHPS® Hospice Survey vendor to conduct the survey on their behalf. Hospices are responsible for making sure their respective survey vendors meet all data submission

deadlines. Vendor failures to submit data on time are the responsibility of the hospices. We invite public comment on this proposal.

d. Public Reporting of CAHPS® Hospice Survey Results

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

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

We previously finalized a volume-based exemption for CAHPS® Hospice Survey Data Collection and Reporting requirements in the FY 2017 final rule (82 FR 36671). We propose to continue our policy for a volume-based exemption for CAHPS® Hospice Survey Data Collection for FY 2023 and every year thereafter. For example, for the FY 2023 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2020 through December 31, 2020 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements (corresponds to the CY 2021 data collection period). To qualify, hospices must submit an exemption request form for the FY 2023 APU. The exemption request form is available on the official CAHPS® Hospice Survey website: <http://www.hospiceCAHPSsurvey.org>.

Hospices that intend to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2020 through December 31, 2020 (reference year). The due date for submitting the exemption request form for the FY 2023 APU is December 31, 2021. Exemptions for size are active for 1 year only. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization needs to request the exemption annually for every applicable FY APU period.

For FY 2024 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2021 through December 31, 2021 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements. Hospices that intend to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2021 through December 31, 2021. The due date for submitting the exemption request form for the FY 2024 APU is December 31, 2022. Exemptions for size are active for 1 year only. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization must request the exemption annually for every applicable FY APU period.

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

TABLE 19—SIZE EXEMPTION KEY DATES FY 2023, FY 2024 AND FY 2025

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

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

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

Specifically, hospices that are notified about their Medicare CCN after January 1, 2021 are exempted from the FY 2023 APU CAHPS® Hospice Survey requirements due to newness. Likewise, hospices notified about their Medicare CCN after January 1, 2022 are exempted from the FY 2024 APU CAHPS® Hospice Survey requirements due to newness. Hospices notified about their Medicare CCN after January 1, 2023 are exempted from the FY 2025 APU CAHPS® Hospice Survey requirements due to newness. No action is required on the part of the hospice to receive this exemption. The newness exemption is a one-time exemption from the survey. We encourage hospices to keep the letter they receive providing them with their CCN. The letter can be used to show when you received your number.

We propose that this newness exemption to the CAHPS® Hospice Survey will apply to all future years. We invite public comment on this proposal.

g. Requirements for the FY 2023 APU

To meet participation requirements for the FY 2023 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2021 through December 2021 (all 12 months) to receive their full payment for the FY 2023 APU. All data submission deadlines for the FY 2023 APU are in Table 20. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the control of the provider as discussed above.

TABLE 20—CAHPS® HOSPICE SURVEY DATA SUBMISSION DATES FOR THE APU IN FY 2023, FY 2024, AND FY 2025

Sample months ¹ (month of death)	CAHPS Quarterly data submission deadlines ²
FY 2023 APU	
CY January–March 2021 (Quarter 1).	August 11, 2021.

TABLE 20—CAHPS® HOSPICE SURVEY DATA SUBMISSION DATES FOR THE APU IN FY 2023, FY 2024, AND FY 2025—Continued

CY April–June 2021 (Q2).	November 10, 2021.
CY July–September 2021 (Q3).	February 9, 2022.
CY October–December 2021 (Q4).	May 11, 2022.

FY 2024 APU

CY January–March 2022 (Q1).	August 10, 2022.
CY April–June 2022 (Q2).	November 9, 2022.
CY July–September 2022 (Q3).	February 8, 2023.
CY October–December 2022 (Q4).	May 10, 2023.

FY 2025 APU

CY January–March 2023 (Q1).	August 9, 2023.
CY April–June 2023 (Q2).	November 8, 2023.
CY July–September 2023 (Q3).	February 14, 2024.
CY October–December 2023 (Q4).	May 8, 2024.

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

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

h. Requirements for the FY 2024 APU

To meet participation requirements for the FY 2024 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2022 through December 2022 (all 12 months) to receive their full payment for the FY 2024 APU. All data submission deadlines for the FY 2024 APU are in Table 20. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 20 for all APU periods listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the control of the provider as discussed above.

i. Requirements for the FY 2025 APU

To meet participation requirements for the FY 2025 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2023 through December 2023 (all 12 months) to

receive their full payment for the FY 2025 APU. All data submission deadlines for the FY 2025 APU are in Table 20. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 20 for all APU periods listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the control of the provider as discussed above.

j. For Further Information About the CAHPS® Hospice Survey

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

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

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any quality data submitted by hospices available to the public. These procedures shall ensure that a hospice has the opportunity to review the data that is to be made public prior to such data being made public; the data will be available on our public website.

To meet the Affordable Care Act’s requirement for making quality measure data public, we launched the Hospice Compare website in August 2017. This website allows consumers, providers, and other stakeholders to search for all Medicare-certified hospice providers and view their information and quality measure scores. Since its release, the CMS Hospice Compare website has reported 7 HIS Measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617). In February 2018, CAHPS® Hospice Survey measures (NQF #2651) were added to the website.

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

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

First, we assess the reliability and validity of each quality measure to determine the scientific acceptability of each measure. This acceptability analysis is the first step in determining a measure’s readiness for public reporting. We evaluate the quality

measures using the NQF Measure Evaluation Criteria found on the NQF website here: http://www.qualityforum.org/Masuring_Performance/Subsubmitting_Standards/Measure_Evaluation_Criteria.aspx#scientific. Analyses to assess scientific acceptability of new measures are important to determine if the measure produces reliable and credible results when implemented. Reliability testing demonstrates that a measure is correctly specified by ensuring that “measure data elements are repeatable, producing the same results a high proportion of time when assessed in the same population in the same time period and/or that the measure score is precise.” Validity testing demonstrates that measure specifications are consistent with the focus of the measure and that the measure score can accurately distinguish between quality of care provided by providers. Reliability and validity are tested at both the data item and quality measure levels. For example, at the item-level, we examine the missing data rate and cross validate the data elements between the assessment data and Medicare claims to ensure validity of the data elements. At the quality measure level, we conduct split-half analysis, consistency analysis across time, stability analysis, and signal-to-noise analysis to demonstrate the reliability of the measures. We examine the relationships between different quality measures assessing similar quality areas to demonstrate the validity of the quality measures.

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

To further inform which of the measures are eligible for public reporting, we then examine the distribution of hospice-level denominator size for each quality measure to assess whether the denominator size is large enough to generate the statistically reliable scores necessary for public reporting. This goal of this analysis is to establish the minimum denominator size for public reporting, which is referred to as reportability analysis. Reportability analysis is necessary because, if a hospice QM score is generated from a denominator that is too small, the observed measure score may be a biased

assessment of the provider’s performance, yielding scores that are statistically unreliable. Thus, we have set a minimum denominator size for public reporting, as well as the data selection period necessary to generate the minimum denominator size for the CMS Hospice Compare website.

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

Because we follow the above outlined processes in determining the readiness for a quality measure to be publicly reported, and perform the necessary analysis to determine and demonstrate that our measures meet the NQF standards for reliability, validity, and reportability, prior to publicly reporting provider performance on these quality metrics, we are proposing to announce to providers, any future intent to publicly report a quality measure on Hospice Compare, including timing, through sub-regulatory means.

Conducting these analyses and announcing measures timeline and readiness for public reporting through sub-regulatory channels will allow us to implement measures for public reporting in a more expeditious, yet still transparent manner, benefitting the public by providing QM data as soon as

it is determined to meet the minimum standards for public reporting. We will continue to provide updates about public reporting of QMs through the normal CMS HQRP communication channels, including postings and announcements on the CMS HQRP website, MLN eNews communications, national provider association calls, and announcements on Open Door Forums. We are soliciting comments on this proposal.

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

We anticipate that we will begin public reporting of the HIS-based Hospice Comprehensive Assessment Measure (NQF #3235), a composite measure of the 7 original HIS Measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617), on the CMS Hospice Compare website in Fall 2019. For more information on how this measure is calculated, please see the HQRP QM User’s Manual v2.00 in the “Downloads” section of the Current Measures page on the CMS HQRP website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>. The reporting period for which the measure will be displayed on the CMS Hospice Compare website will align with the currently established procedures for the 7 HIS measures. For more information about reporting periods, please see the Public Reporting: Key Dates for Providers page on the CMS HQRP website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Key-Dates-for-Providers.html>. We used the analytic approach described above to determine reliability, validity, and reportability of the HIS-based Hospice Comprehensive Assessment Measure (NQF #3235). Reliability and validity testing found that the Hospice Comprehensive Assessment Measure had high reliability and validity. For more information about the reliability and validity of this measure, please see the NQF Palliative and End-of-Life Care Off-Cycle Measure Review 2017 Publication available for download here: http://www.qualityforum.org/Publications/2017/09/Palliative_and_End-of-Life_Care_Off-Cycle_Measure_Review_2017.aspx. Per the approach described above, we then conducted reportability analysis. Based on reportability analysis results, we determined this measure, calculated based on a 12-rolling month data selection period, to be eligible for

public reporting with a minimum denominator size of 20 patient stays. A majority of hospices, using rolling 4 quarters of data, have at least 20 patient stays eligible for the calculation and public reporting of the Hospice Comprehensive Assessment Measure. We plan to begin public reporting of the Hospice Comprehensive Assessment Measure with a minimum denominator size of 20.

We also anticipate that we will begin public reporting of the HIS-based Hospice Visits when Death is Imminent Measure Pair in FY 2019. This same analytic approach described above will be applied to determine the reliability, validity, and reportability of the Hospice Visits when Death is Imminent Measure Pair. This measure pair assesses hospice staff visits to patients at the end of life. Specifications for the Hospice Visits when Death is Imminent measure pair were finalized in the FY 2017 Hospice Final Rule (81 FR 52162). Pending the finalization of our proposal to announce future intentions to publicly display hospice quality measures via sub-regulatory means, the exact timeline for public reporting of this measure pair will be announced through regular sub-regulatory channels once necessary analyses and measure specifications are finalized.

c. Updates to the Public Display of HIS Measures

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

With this framework in mind, we evaluated our measure set and specifically the measure Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (NQF #3235) which we intend to publicly display on the Hospice Compare website in FY 2019. Through feedback received, we have learned that while the 7 original HIS measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF

#1638, and NQF #1617) that represent the individual care processes captured in this composite measure are important, the composite measure provides for consumers a more accessible measure for evaluating the quality of a hospice.

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

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

TABLE 21—MEAN MEASURE SCORE OF THE HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT MEASURE AT ADMISSION AND 7 ORIGINAL HIS COMPONENT MEASURES

Measure title	Measure score (%)
Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (NQF #3235)	71.3
Component Measure: Treatment Preferences (NQF #1641)	98.8
Component Measure: Beliefs/Values (NQF #1647)	95.9
Component Measure: Pain Screening (NQF #1634)	93.2

TABLE 21—MEAN MEASURE SCORE OF THE HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT MEASURE AT ADMISSION AND 7 ORIGINAL HIS COMPONENT MEASURES—Continued

Measure title	Measure score (%)
Component Measure: Pain Assessment (NQF #1637)	72.5
Component Measure: Dyspnea Screening (NQF #1639)	98.5
Component Measure: Dyspnea Treatment (NQF #1638)	92.8
Component Measure: Bowl Regimen (NQF #1617)	97.5

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

This proposal would change only the display of data on Hospice Compare for the HIS-based measure(s). This proposal would not change any current HIS data collection procedures outlined in the FY 2018 Hospice final rule (82 FR 36663 through 36664). Providers would still collect all HIS items in the current version of the HIS (HIS V2.00.0), including the 7 aforementioned component measures. Providers would continue to follow the coding guidelines and policies outlined in the HIS Manual V2.00, which can be found under the Downloads section of the HIS page of the HQRP website <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>. Therefore, this proposal would not impact data collection.

Additionally, because the composite measure is composed of the 7 aforementioned component measures, these component measures would still be reported on CASPER QM reports and HIS provider preview reports for providers' internal quality purposes.

We invite public comment on our proposal to remove from Hospice Compare the direct display of the 7 original HIS measures, allowing for the reformatting of the display of these measures under the composite measure, once the Hospice Comprehensive Assessment Measure is displayed.

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

In the FY 2016 Hospice Wage Index final rule (80 FR 47199), we announced that we would make available hospice data in a public data set, the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (PUF), as part of our ongoing efforts to make healthcare more transparent, affordable, and accountable. Hospice data has been available at the provider-level in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF since 2016 and is located at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice.html>. The primary data source for the Hospice PUF is the CMS Chronic Condition Data Warehouse (CCW), a database with 100 percent of Medicare enrollment and fee-for-service adjudicated claims data.

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

As part of our ongoing efforts to make the Hospice Compare website more informative to our beneficiaries, loved ones, and their families, we propose to post information from these PUF and/or other publicly available CMS data to the Hospice Compare website in a user-

friendly way. We propose to use information available in these public files to develop a new section of the Hospice Compare website that would provide additional information along with the HIS and CAHPS® quality measures and demographic information already displayed. Other Compare websites, such as the Nursing Home Compare and the End Stage Renal Disease Compare websites, have an information section similar to what we anticipate posting.

Information on the Hospice Compare website for each hospice includes data from the PUF and/or other publicly available CMS data displayed in a consumer-friendly format. This means that we may display the data as shown from the PUF or present the data after additional calculations. For example, the data could be averaged over multiple years, displayed as a percentage rather than the raw number so it has meaning to end-users, or other calculations in a given year or over multiple years. Any calculation will be performed on data exclusively from the source file like the PUF or other publicly available CMS data. The data may be displayed with supporting narrative when needed to make the data more understandable.

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

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

While these types of information are not quality measures, they capture information that many consumers seek during the provider selection process and, therefore, will help them to make an informed decision. For example, information about conditions treated by the hospice could show a patient with dementia if a hospice specializes or is experienced in caring for patients with this condition. Additionally, if a patient has a specific need, like receiving hospice care in a nursing home, information from the PUF could help this patient or their loved ones determine if a provider in their service

area has provided care in this setting. Analyses of the PUF data show variation between hospice providers in the data points outlined above, indicating that these data points could be meaningful to consumers in comparing services provided by hospices based on the factors most important to them. PUF data can serve as one more piece of information, along with quality of care metrics from the HIS and CAHPS® Hospice Survey, to help consumers effectively and efficiently compare hospice providers and make an informed decision about their care in a stressful time.

By averaging or trending data over multiple years, we make it fairer so that the data applies to hospices broadly regardless of size or location or other factors. We anticipate that over time and as appropriate, we may add other items from the PUF or other publicly available CMS data to the Hospice Compare website via sub-regulatory processes and would plan to inform the public via regular HQRP communication strategies, such as Open Door Forums, Medicare Learning Network, Spotlight announcements and other opportunities. We invite public comment on these proposals.

IV. Request for Information on Possible Establishment of CMS Patient Health and Safety Requirements for Hospitals and Other Medicare-Participating Providers and Suppliers for Electronic Transfer of Health Information

Currently, Medicare- and Medicaid-participating providers and suppliers are at varying stages of adoption of health information technology (health IT). Many hospitals have adopted electronic health records (EHRs), and the Centers for Medicare & Medicaid Services (CMS) has provided incentive payments to eligible hospitals, critical access hospitals (CAHs), and eligible professionals who have demonstrated meaningful use of certified EHR technology under the Medicare EHR Incentive Program. As of 2015, 96 percent of Medicare-participating non-federal acute care hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care.¹³ While both adoption of EHRs and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist. Routine electronic transfer of information post-discharge has not

¹³ These statistics can be accessed at <https://dashboard.healthit.gov/quickstats/pages/FIG-Hospital-EHR-Adoption.php>.

been achieved by providers and suppliers in many localities and regions throughout the nation.

We are firmly committed to the use of certified health IT and interoperable EHR systems for electronic healthcare information exchange to effectively help hospitals and other Medicare-participating providers and suppliers improve internal care delivery practices, support the exchange of important information across care team members during transitions of care, and enable reporting of specified electronically clinical quality measures (eCQMs). The Office of the National Coordinator for Health Information Technology (ONC) acts as the principal federal entity charged with coordination of nationwide efforts to implement and use health IT and the electronic exchange of health information on behalf of the Department of Health and Human Services (HHS).

In 2015, ONC finalized the 2015 Edition health IT certification criteria (2015 Edition), the most recent criteria for health IT to be certified under the ONC Health IT Certification Program. The 2015 Edition facilitates greater interoperability for several clinical health information purposes and enables health information exchange through new and enhanced certification criteria, standards, and implementation specifications. CMS requires eligible hospitals and CAHs in the Medicare and Medicaid EHR Incentive Programs and eligible clinicians in the Quality Payment Program to use EHR technology certified to the 2015 Edition beginning in CY 2019.

In addition, several important initiatives will be implemented over the next several years to provide hospitals and other participating providers and suppliers with access to robust infrastructure that will enable routine electronic exchange of health information. Section 4003 of the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, and amended section 3000 of the Public Health Service Act (42 U.S.C. 300jj), requires HHS to take steps to advance the electronic exchange of health information and interoperability for participating providers and suppliers in various settings across the care continuum. Specifically, the Congress directed that ONC “. . . for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally.” In January 2018, ONC

released a draft version of its proposal for the Trusted Exchange Framework and Common Agreement,¹⁴ which outlines principles and minimum terms and conditions for trusted exchange to enable interoperability across disparate health information networks (HINs). The Trusted Exchange Framework (TEF) is focused on achieving the following four important outcomes in the long-term:

- Professional care providers, who deliver care across the continuum, can access health information about their patients, regardless of where the patient received care.
- Patients can find all of their health information from across the care continuum, even if they don't remember the name of the professional care provider they saw.
- Professional care providers and health systems, as well as public and private health care organizations and public and private payer organizations accountable for managing benefits and the health of populations, can receive necessary and appropriate information on groups of individuals without having to access one record at a time, allowing them to analyze population health trends, outcomes, and costs; identify at-risk populations; and track progress on quality improvement initiatives.
- The health IT community has open and accessible application programming interfaces (APIs) to encourage entrepreneurial, user-focused innovation that will make health information more accessible and improve EHR usability.

ONC will revise the draft TEF based on public comment and ultimately release a final version of the TEF that will subsequently be available for adoption by HINs and their participants seeking to participate in nationwide health information exchange. The goal for stakeholders that participate in, or serve as, a HIN is to ensure that participants will have the ability to seamlessly share and receive a core set of data from other network participants in accordance with a set of permitted purposes and applicable privacy and security requirements. Broad adoption of this framework and its associated exchange standards is intended to both achieve the outcomes described above while creating an environment more conducive to innovation.

In light of the widespread adoption of EHRs along with the increasing availability of health information

exchange infrastructure predominantly among hospitals, we are interested in hearing from stakeholders on how we could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (that is, the Conditions of Participation (CoPs) and Conditions for Coverage (CfCs)) to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: Requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider through electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) through electronic means if requested.

On November 3, 2015, we published a proposed rule (80 FR 68126) to implement the provisions of the IMPACT Act and to revise the discharge planning CoP requirements that hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals (IRFs), Inpatient Psychiatric Hospitals (IPFs), Children's Hospitals, and Cancer Hospitals), critical access hospitals (CAHs), and home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. However, several of the proposed requirements directly address the issue of communication between providers and between providers and patients, as well as the issue of interoperability:

- Hospitals and CAHs would be required to transfer certain necessary medical information and a copy of the discharge instructions and discharge summary to the patient's practitioner, if the practitioner is known and has been clearly identified;
- Hospitals and CAHs would be required to send certain necessary medical information to the receiving facility/post-acute care providers, at the time of discharge; and
- Hospitals, CAHs and HHAs, would need to comply with the IMPACT Act requirements that would require hospitals, CAHs, and certain post-acute care providers to use data on quality

¹⁴ The draft version of the trusted Exchange Framework may be accessed at <https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement>.

measures and data on resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

We also published another proposed rule (81 FR 39448), on June 16, 2016, that updated a number of CoP requirements that hospitals and CAHs must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. One of the proposed hospital CoP revisions in this rule directly addresses the issues of communication between providers and patients, patient access to their medical records, and interoperability. We proposed that patients have the right to access their medical records, upon an oral or written request, in the form and format requested by such patients, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

Additionally, we specifically invite stakeholder feedback on the following questions regarding possible new or revised CoPs/CfCs for interoperability and electronic exchange of health information:

- If CMS were to propose a new CoP/CfC standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?

- Should CMS propose new CoPs/CfCs for hospitals and other participating providers and suppliers to ensure a patient's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient access as well as interoperability?

- Are new or revised CMS CoPs/CfCs for interoperability and electronic exchange of health information necessary to ensure patients and other treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will

this be achieved in the next few years through existing Medicare and Medicaid policies, Health Insurance Portability and Accountability Act of 1996 (HIPAA), and implementation of relevant policies in the 21st Century Cures Act?

- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?

- Do stakeholders believe that new or revised CMS CoPs/CfCs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient care and safety?

- Under new or revised CoPs/CfCs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient discharge/transfer summaries shared directly with the patient or with the receiving provider or supplier, either directly transferred with the patient or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient cannot receive the information electronically?

- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs if they are proposed and finalized in the future?

- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs if they are proposed and finalized in the future? Should exceptions under the Quality Payment Program including Certified Electronic Health Record Technology hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

We would also like to directly address the issue of communication between hospitals (as well as the other providers

and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records. Privacy and security of patient data will be at the center of all our efforts in this area. CMS must protect the confidentiality of patient data, and CMS is completely aligned with the Veterans Affairs, the National Institutes of Health, ONC, and the rest of the federal government, on this objective. While some Medicare beneficiaries have had, for quite some time, the ability to download their Medicare claims information, in pdf or Excel formats, through the CMS Blue Button platform, the information was provided without any context or other information that would help beneficiaries understand what the data was really telling them. For beneficiaries, their claims information is useless if it is either too hard to obtain or, as was the case with the information provided through previous versions of Blue Button, hard to understand. In an effort to fully contribute to the federal government's MyHealthEData initiative, CMS developed and launched the new Blue Button 2.0, which represents a major step toward giving patients meaningful control of their health information in an easy-to-access and understandable way. Blue Button 2.0 is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to secure applications, services, and research programs they trust. The possibilities for better care through Blue Button 2.0 data are exciting, and might include enabling the creation of health dashboards for Medicare beneficiaries to view their health information in a single portal, or allowing beneficiaries to share complete medication lists with their doctors to prevent dangerous drug interactions.

To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, we invite members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to

access and control their medical records. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs or CfCs for hospitals and other participating providers and suppliers. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.

Please note, this is a Request for Information only. Respondents are encouraged to provide complete but concise and organized responses, including any relevant data and specific examples. However, respondents are not required to address every issue or respond to every question discussed in this Request for Information to have their responses considered. In accordance with the implementing regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4), all responses will be considered provided they contain information we can use to identify and contact the commenter, if needed.

This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This Request for Information does not commit the United States (U.S.) Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will be solely at the interested party's expense.

We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement for additional information pertaining to this request. In addition, we note that CMS

will not respond to questions about the policy issues raised in this Request for Information. We will not respond to comment submissions in response to this Request for Information in the FY 2019 IPPS/LTCH PPS final rule. Rather, we will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. We may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential.

This Request for Information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. We may publically post the public comments received, or a summary of those public comments.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

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

A. ICRs Regarding Hospice Item Set

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

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

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

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

In section III.E of this proposed rule, we propose removal of the 7 original HIS measures from public reporting display on Hospice Compare. This proposal would not change any current HIS data collection procedures outlined in the FY 2018 Hospice final rule (82 FR 36663 through 36664). The HIS V2.00.0 was approved by the OMB on April 17, 2017 under control number 0938–1153 for 1 year. The information collection request (ICR) is currently pending OMB approval for 3 years. We are not proposing any new updates or additional collections of information in this proposed rule in regards to the HIS.

B. ICRs Regarding CAHPS® Hospice Survey Information Collection Requirements

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

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. The requirements are not effective until they have been approved by OMB.

We invite public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS-1692-P) and, where applicable, the ICR's CFR citation, CMS ID number, and OMB control number.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access our website address at <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html>.
2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov.
3. Call the Reports Clearance Office at (410) 786-1326. See this rule's **DATES** and **ADDRESSES** sections for the comment due date and for additional instructions.

VI. Response to Comments

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

VII. Regulatory Impact Analysis

A. Statement of Need

This proposed rule meets the requirements of our regulations at § 418.306(c), which requires annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of Core-Based Statistical Areas (CBSAs), or previously used Metropolitan Statistical Areas (MSAs). This proposed rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2018 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. In addition, the payment rate updates may be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension

under conditions specified in section 1814(i)(1)(C)(v) of the Act). Lastly, section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices and this rule discusses changes in the requirements for the hospice quality reporting program in accordance with section 1814(i)(5) of the Act.

B. Overall Impacts

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an increase of \$340 million in payments to hospices, resulting from the hospice payment update percentage of 1.8 percent. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2018 to FY 2019. Using the most recent data available at the time of rulemaking, in this case FY 2017 hospice claims data, we apply the current FY 2018 wage index and labor-related share values to the level of care per diem payments and SIA payments for each day of hospice care to simulate FY 2018 payments. Then, using the same FY 2017 data, we apply the FY 2019 wage index and labor-related share values to simulate FY 2019 payments. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety

effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) (Having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as "economically significant")); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

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

C. Anticipated Effects

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than \$7.5 million to \$38.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. HHS's practice in interpreting the RFA is to consider effects economically "significant" only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The effect of the FY 2018 hospice payment update percentage results in an overall increase in estimated hospice payments of 1.8 percent, or \$340 million. Therefore, the Secretary has determined that this proposed rule would not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 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 would only affect hospices. Therefore, the Secretary has determined that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. The 2018 UMRA threshold is \$150 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 \$150 million or more.

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

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review.

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

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

As we noted in section III.C of this proposed rule, we are making optional the requirement to submit specific, detailed data regarding drugs on hospice claims, which could result in a significant reduction of burden to Medicare hospices. We estimate that the total number of lines on hospice claims could be reduced by 21.5 million in the

aggregate, which corresponds to an average reduction in the total number of lines on hospices claims by 5,000 per hospice.

D. Detailed Economic Analysis

The FY 2019 hospice payment impacts appear in Table 22. We tabulate the resulting payments according to the classifications in Table 22 (for example, facility type, geographic region, facility ownership), and compare the difference between current and future payments to determine the overall impact.

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

The third column shows the effect of the annual update to the wage index. This represents the effect of using the FY 2019 hospice wage index. The aggregate impact of this change is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2019 hospice wage index.

The fourth column shows the effect of the hospice payment update percentage for FY 2019. The proposed FY 2019 hospice payment update percentage of 1.8 percent is mandated by section 1814(i)(1)(C) of the Act, and is constant for all providers.

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

As illustrated in Table 22, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 22—PROJECTED IMPACT TO HOSPICES FOR FY 2019

	Number of providers	Updated wage data (%)	FY 2019 hospice payment update (%)	FY 2019 total change (%)
(1)	(2)	(3)	(4)	(5)
All Hospices	4,408	0.0	1.8	1.8
Urban Hospices	3,523	0.0	1.8	1.8
Rural Hospices	885	0.1	1.8	1.9
Urban Hospices—New England	124	–0.1	1.8	1.7
Urban Hospices—Middle Atlantic	249	0.1	1.8	1.9
Urban Hospices—South Atlantic	443	–0.2	1.8	1.6
Urban Hospices—East North Central	397	–0.1	1.8	1.7
Urban Hospices—East South Central	149	0.0	1.8	1.8
Urban Hospices—West North Central	241	0.2	1.8	2.0
Urban Hospices—West South Central	691	0.4	1.8	2.2
Urban Hospices—Mountain	354	–0.3	1.8	1.5
Urban Hospices—Pacific	835	0.2	1.8	2.0

TABLE 22—PROJECTED IMPACT TO HOSPICES FOR FY 2019—Continued

(1)	(2)	(3)	(4)	(5)
	Number of providers	Updated wage data (%)	FY 2019 hospice payment update (%)	FY 2019 total change (%)
Urban Hospices—Outlying	40	0.4	1.8	2.2
Rural Hospices—New England	27	1.5	1.8	3.3
Rural Hospices—Middle Atlantic	35	0.0	1.8	1.8
Rural Hospices—South Atlantic	108	0.0	1.8	1.8
Rural Hospices—East North Central	137	0.0	1.8	1.8
Rural Hospices—East South Central	111	0.0	1.8	1.8
Rural Hospices—West North Central	167	0.3	1.8	2.1
Rural Hospices—West South Central	160	0.2	1.8	2.0
Rural Hospices—Mountain	92	-0.4	1.8	1.4
Rural Hospices—Pacific	42	0.1	1.8	1.9
Rural Hospices—Outlying	6	-0.3	1.8	1.5
0–3,499 RHC Days (Small)	975	0.3	1.8	2.1
3,500–19,999 RHC Days (Medium)	2,036	0.1	1.8	1.9
20,000+ RHC Days (Large)	1,397	0.0	1.8	1.8
Non-Profit Ownership	1,026	0.0	1.8	1.8
For Profit Ownership	2,830	0.0	1.8	1.8
Government Ownership	141	0.2	1.8	2.0
Other Ownership	411	0.0	1.8	1.8
Freestanding Facility Type	3,608	0.0	1.8	1.8
HHA/Facility-Based Facility Type	800	-0.1	1.8	1.7

Source: FY 2017 hospice claims from the Chronic Conditions Data Warehouse (CCW) Research Identifiable Files (RIFs) as of February 2, 2018.

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

E. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table 23, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 23 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 4,408 hospices in our impact analysis file, which was constructed using FY 2017 claims available in February 2018. All expenditures are classified as transfers to hospices.

TABLE 23—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM FY 2018 TO FY 2019—Continued

Category	Transfers
From Whom to Whom?.	Federal Government to Medicare Hospices.

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

F. Regulatory Reform Analysis Under E.O. 13771

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

deregulatory action for the purposes of Executive Order 13771.

G. Conclusion

We estimate that aggregate payments to hospices in FY 2019 will increase by \$340 million, or 1.8 percent, compared to payments in FY 2018. We estimate that in FY 2019, hospices in urban and rural areas will experience, on average, 1.8 percent and 1.9 percent increases, respectively, in estimated payments compared to FY 2018. Hospices providing services in the urban West South Central and Outlying regions and the rural New England region would experience the largest estimated increases in payments of 2.2 percent and 3.3 percent, respectively. Hospices serving patients in rural areas in the Mountain region would experience, on average, the lowest estimated increase of 1.4 percent in FY 2019 payments.

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

List of Subjects in 42 CFR Part 418

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

TABLE 23—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM FY 2018 TO FY 2019

Category	Transfers
Annualized Monetized Transfers.	\$ 340 million.*

For the reasons set forth in the preamble, the Centers for Medicare & 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 418.3 is amended by revising paragraph (1) of the definition of “Attending physician” and revising the definition of “Cap period” to read as follows:

§ 418.3 Definitions.

* * * * *

Attending physician * * *

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

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

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

* * * * *

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

* * * * *

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

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

* * * * *

(f)(1) Effective January 1, 2019, Medicare pays for attending physician services provided by physician assistants to Medicare beneficiaries who have elected the hospice benefit and who have selected a physician assistant as their attending physician. This applies to physician assistants without regard to whether they are hospice employees.

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

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

(ii) Services are medically reasonable and necessary;

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

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

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

Dated: April 16, 2018.

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

Dated: April 17, 2018.

Alex M. Azar II,
Secretary, Department of Health and Human Services.

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