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Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Final Rule

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Part 418**

**[CMS–1629–F]**

**RIN 0938–AS39**

# Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

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

**ACTION:** Final rule.

**SUMMARY:** This final rule will update the hospice payment rates and the wage index for fiscal year (FY) 2016 (October 1, 2015 through September 30, 2016), including implementing the last year of the phase-out of the wage index budget neutrality adjustment factor (BNAF). Effective on January 1, 2016, this rule also finalizes our proposals to differentiate payments for routine home care (RHC) based on the beneficiary's length of stay and implement a service intensity add-on (SIA) payment for services provided in the last 7 days of a beneficiary's life, if certain criteria are met. In addition, this rule will implement changes to the aggregate cap calculation mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the federal fiscal year starting in FY 2017, make changes to the hospice quality reporting program, clarify a requirement for diagnosis reporting on the hospice claim, and discuss recent hospice payment reform research and analyses.

**DATES:** *Effective Date:* These regulations are effective on October 1, 2015 and the implementation date for the RHC rates and the SIA payment rates will be January 1, 2016.

**FOR FURTHER INFORMATION CONTACT:** Debra Dean-Whittaker, (410) 786–0848 for questions regarding the CAHPS® Hospice Survey. Michelle Brazil, (410) 786–1648 for questions regarding the hospice quality reporting program. For general questions about hospice payment policy please send your inquiry via email to: *hospicepolicy@cms.hhs.gov*.

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

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## Acronyms

Because of the many terms to which we refer by acronym in this final rule,

we are listing the acronyms used and their corresponding meanings in alphabetical order below:

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

## I. Executive Summary

### *A. Purpose*

This final rule updates the payment rates for hospices for fiscal year (FY) 2016, as required under section 1814(i) of the Social Security Act (the Act) and reflects the final year of the 7-year Budget Neutrality Adjustment Factor (BNAF) phase-out finalized in the FY 2010 Hospice Wage Index final rule (74 FR 39407). Our updates to payment rates for hospices also include changes to the hospice wage index by incorporating the new Office of Management and Budget (OMB) core-based statistical area (CBSA) definitions, changes to the aggregate cap calculation required by section 1814(i)(2)(B)(ii) of the Act, and includes aligning the cap accounting year for both the inpatient cap and the hospice aggregate cap with the federal fiscal year starting in FY 2017. In addition, pursuant to the discretion granted the Secretary under section 1814(i)(6)(D)(i) of the Act and effective on January 1, 2016; this rule will create two different payment rates for routine home care (RHC) that will result in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for days 61 and over of hospice care; and a service intensity add-on (SIA) payment that will result in an add-on payment equal to the Continuous Home Care (CHC) hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse (RN) or social worker provided during the last 7 days of a beneficiary's life, if certain criteria are met. In addition, section 3004(c) of the Affordable Care Act established a quality reporting program for hospices. In accordance with section 1814(i)(5)(A) of the Act, starting in FY 2014, hospices that have failed to meet quality reporting requirements receive a 2 percentage point reduction to their payment update percentage. Although this rule does not implement new quality measures, it provides updates on the hospice quality reporting program. Finally, this rule includes a clarification regarding diagnosis reporting on the hospice claim form.

### *B. Summary of the Major Provisions*

Section III.A of this rule provides an update on hospice payment reform research and analysis. As a result of the hospice payment reform research and analysis conducted over the past several years, some of which is described in section III.A of this rule and in various technical reports available on the CMS Hospice Center Web page (*http://www.cms.gov/Center/Provider-Type/Hospice-Center.html*) we proposed several provisions to address issues identified and strengthen the Medicare hospice benefit. Section III.B implements the creation of two different payment rates for RHC that will result in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for days 61 and over of hospice care. Section III.B also implements SIA payment, in addition to the per diem rate for the RHC level of care, that will result in an add-on payment equal to the CHC hourly payment rate multiplied by the amount of direct patient care provided by an RN or social worker that occurs during the last 7 days of a beneficiary's life, if certain criteria are met.

In section III.C.1 of this rule, we update the hospice wage index using a 50/50 blend of the existing CBSA designations and the new CBSA designations outlined in a February 28, 2013, OMB bulletin. Section III.C.2 of this rule implements year 7 of the 7-year BNAF phase-out finalized in the FY 2010 Hospice Wage Index final rule (74 FR 39407). In section III.C.3, we update the hospice payment rates for FY 2016 by 1.6 percent. Section III.C.4 implements changes mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), in which the aggregate cap for accounting years that end after September 30, 2016 and before October 1, 2025, will be updated by the hospice payment update percentage rather than using the consumer price index for urban consumers (CPI–U). Specifically, the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016, will be updated by the FY 2016 hospice update percentage for hospice care. In

addition, in section III.D, we are aligning the cap accounting year for both the inpatient cap and the hospice aggregate cap with the fiscal year for FY 2017 and later. We believe that this will allow for the timely implementation of the IMPACT Act changes while better aligning the cap accounting year with the timeframe described in the IMPACT Act.

In section III.E of this rule, we discuss updates to the hospice quality reporting program, including participation requirements for current year (CY) 2015 regarding the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey, and remind the hospice industry that last year we set the July 1, 2014 implementation date for the Hospice Item Set (HIS) and the January 1, 2015 implementation date for the CAHPS® Hospice Survey. More than seven new quality measures will be derived from these tools; therefore, no new measures were implemented this year. Also, Section III.E of this rule will make changes related to the reconsideration process, extraordinary circumstance extensions or exemptions, hospice quality reporting program (HQRP) eligibility requirements for newly certified hospices and new data submission timeliness requirements and compliance thresholds. Finally, in Section III.F, we clarify 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 refinements. We believe that reporting of all diagnoses on the hospice claim aligns with current coding guidelines as well as admission requirements for hospice certifications.

*C. Summary of Impacts*

TABLE 1—IMPACT SUMMARY TABLE

| Provision description | Transfers |
|---|---|
| FY 2016 Hospice Wage Index and Payment Rate Update. | The overall economic impact of this final rule is estimated to be $160 million in increased payments to hospices during FY 2016. |

## II. Background

*A. Hospice Care*

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

Medicare regulations define ''palliative care'' as ''patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.'' (42 CFR 418.3) Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit. *See also* Hospice Conditions of Participation final rule (73 FR 32088) (2008). The goal of palliative care in hospice is to improve the quality of life of individuals, and their families, facing the issues associated with a life-threatening illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other issues. This is achieved by the hospice interdisciplinary team working with the patient and family to develop a comprehensive care plan focused on coordinating care services, reducing unnecessary diagnostics or ineffective therapies, and offering ongoing conversations with individuals and their families about changes in their condition. It is expected that this comprehensive care plan will shift over time to meet the changing needs of the patient and family as the individual approaches the end of life.

Medicare hospice care is palliative care for individuals with a prognosis of living 6 months or less if the terminal illness runs its normal course. When an individual is terminally ill, many health problems are brought on by underlying condition(s), as bodily systems are interdependent. In the June 5, 2008 Hospice Conditions of Participation final rule (73 FR 32088), we stated that ''the medical director must consider the primary terminal condition, related diagnoses, current subjective and objective medical findings, current medication and treatment orders, and information about unrelated conditions when considering the initial certification of the terminal illness.'' As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient's attending physician (if any) and the hospice medical director must certify that the individual is ''terminally ill,'' as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3 that is, the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. The certification of terminal illness must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, as set out at § 418.22(b)(3).

The goal of hospice care is to make the hospice patient as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment. Hospice care uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through the use of a broad spectrum of professional and other caregivers and volunteers. While the goal of hospice care is to allow for the individual to remain in his or her home environment, circumstances during the end-of-life may necessitate short-term inpatient admission to a hospital, skilled nursing facility (SNF), or hospice facility for procedures necessary for pain control or acute or chronic symptom management that cannot be managed in any other setting. These acute hospice care services are to ensure that any new or worsening symptoms are intensively addressed so that the individual can return to his or her home environment at a home level of care. Short-term, intermittent, inpatient respite services are also available to the

family of the hospice patient when needed to relieve the family or other caregivers. Additionally, an individual can receive continuous home care during a period of crisis in which an individual requires primarily continuous nursing care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. Continuous home care may be covered on a continuous basis for as much as 24 hours a day, and these periods must be predominantly nursing care in accordance with our regulations at § 418.204. A minimum of 8 hours of nursing, 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 or patient care representatives with disabilities consistent with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, and to provide language access for such persons who are limited in English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at *http://www.hhs.gov/ocr/civilrights*.

*B. History of the Medicare Hospice Benefit*

Before the creation of the Medicare hospice benefit, hospice programs were originally operated by volunteers who cared for the dying. During the early development stages of the Medicare hospice benefit, hospice advocates were clear that they wanted a Medicare benefit that provided all-inclusive care for terminally-ill individuals, provided pain relief and symptom management, and offered the opportunity to die with dignity in the comfort of one's home rather than in an institutional setting.[1] As stated in the August 22, 1983 proposed rule entitled ''Medicare Program; Hospice Care'' (48 FR 38146), ''the hospice experience in the United States has placed emphasis on home care. It offers physician services, specialized nursing services, and other forms of care in the home to enable the terminally ill individual to remain at home in the company of family and friends as long as possible.'' The concept of a patient ''electing'' the hospice benefit and being certified as terminally ill were two key components of the legislation responsible for the creation of the Medicare Hospice Benefit (section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), (Pub. L. 97–248)). Section 122 of TEFRA created the Medicare Hospice benefit, which was implemented on November 1, 1983. Under sections 1812(d) and 1861(dd) of the Act, codified at 42 U.S.C. 1395d(d) and 1395x(dd), we provide coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a Medicare-certified hospice. Our regulations at § 418.54(c) stipulate that the comprehensive hospice assessment must identify the patient's physical, psychosocial, emotional, and spiritual needs related to the terminal illness and related conditions, and address those needs in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors: the nature and condition causing admission (including the presence or lack of objective data and subjective complaints); complications and risk factors that affect care planning; functional status; imminence of death; and severity of symptoms (§ 418.54(c)). The Medicare hospice benefit requires the hospice to cover all reasonable and necessary palliative care related to the terminal prognosis, as described in the patient's plan of care. The December 16, 1983 Hospice final rule (48 FR 56008) requires hospices to cover care for interventions to manage pain and symptoms. Additionally, the hospice Conditions of Participation (CoPs) at § 418.56(c) require that the hospice must provide all reasonable and necessary services for the palliation and management of the terminal illness, related conditions and interventions to manage pain and symptoms. Therapy and interventions must be assessed and managed in terms of providing palliation and comfort without undue symptom burden for the hospice patient or family.[2] In the December 16, 1983 Hospice final rule (48 FR 56010 through 56011), regarding what is related versus unrelated to the terminal illness, we stated: ''. . . we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case-by-case basis. It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients.'' Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis; all conditions are considered to be related to the terminal prognosis. It is also the responsibility of the hospice physician to document why a patient's medical needs will be unrelated to the terminal prognosis.

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

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

*C. Services Covered by the Medicare Hospice Benefit*

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

[1] Connor, Stephen. (2007). Development of Hospice and Palliative Care in the United States. OMEGA. 56(1), p89–99.

[2] Paolini, DO, Charlotte. (2001). Symptoms Management at End of Life. JAOA. 101(10). p609–615.

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

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

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

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

*D. Medicare Payment for Hospice Care*

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

1. Omnibus Budget Reconciliation Act of 1989

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

2. Balanced Budget Act of 1997

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

3. FY 1998 Hospice Wage Index Final Rule

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

4. FY 2010 Hospice Wage Index Final Rule

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

2010, a 7-year phase-out of the BNAF began (August 6, 2009 FY 2010 Hospice Wage Index final rule, (74 FR 39384)), with a 10 percent reduction in FY 2010, an additional 15 percent reduction for a total of 25 percent in FY 2011, an additional 15 percent reduction for a total 40 percent reduction in FY 2012, an additional 15 percent reduction for a total of 55 percent in FY 2013, and an additional 15 percent reduction for a total 70 percent reduction in FY 2014. The phase-out will continue with an additional 15 percent reduction for a total reduction of 85 percent in FY 2015, and an additional 15 percent reduction for complete elimination in FY 2016. We note that the BNAF is an adjustment which increases the hospice wage index value. Therefore, the BNAF reduction is a reduction in the amount of the BNAF increase applied to the hospice wage index value. It is not a reduction in the hospice wage index value 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 will be annually reduced by changes in economy-wide productivity, as specified in section 1886(b)(3)(B)(xi)(II) of the Act, as amended by section 3132(a) of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act (Pub. L. 111–152) (collectively referred to as the Affordable Care 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 as specified in section 1814(i)(1)(C)(v) of the Act).

In addition, sections 1814(i)(5)(A) through (C) of the Act, as amended 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 update reduced by 2 percentage points.

Section 1814(a)(7)(D)(i) of the Act was amended by section 3132(b)(2)(D)(i) of the Affordable Care Act, and requires effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary's hospice care prior to the 180th-day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, we finalized in the CY 2011 Home Health Prospective Payment System final rule (75 FR 70435) that the 180th-day recertification and subsequent recertifications corresponded to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as amended 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 would capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determines to be appropriate. The data collected may 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 are required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

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

7. FY 2015 Hospice Rate Update Final Rule

When electing hospice, a beneficiary waives Medicare coverage for any care for the terminal illness and related conditions except for services provided by the designated hospice and attending physician. A hospice is to file a Notice of Election (NOE) as soon as possible to establish the hospice election within the claims processing system. Late filing of the NOE can result in inaccurate benefit period data and leaves Medicare vulnerable to paying non-hospice claims related to the terminal illness and related conditions and beneficiaries possibly liable for any cost-sharing associated costs. The FY 2015 Hospice Rate Update final rule (79 FR 50452) finalized a requirement that requires the 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 50454, 50474). Similar to the NOE, the claims processing system must be notified of a beneficiary's discharge from hospice or hospice benefit revocation. This update to the beneficiary's status allows claims from non-hospice providers to process and be paid. Upon live discharge or revocation, the beneficiary immediately resumes the Medicare coverage that had been waived when he or she elected hospice. The FY 2015 Hospice Rate Update final rule also finalized a requirement that requires hospices to file a notice of termination/revocation within 5 calendar days of a beneficiary's live discharge or revocation, unless the hospices have already filed a final claim. This requirement helps to protect beneficiaries from delays in accessing needed care (79 FR 50509).

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

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

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

8. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 became law on October 6, 2014 (Pub. L. 113–185). Section 3(a) of the IMPACT Act mandates that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025, as it was found that surveys of hospices were being performed on an infrequent basis. In addition, the IMPACT Act also implements a provision set forth in the Affordable Care Act that requires medical review of hospice cases involving patients receiving more than 180 days care in select hospices that show a preponderance of such patients, and the IMPACT Act contains a new provision mandating that the aggregate 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 CPI–U for medical care expenditures. Specifically, the 2016 cap year, which starts on November 1, 2015 and ends on October 31, 2016, will be updated by the FY 2016 payment update percentage for hospice care. In accordance with the statute, we will continue to do this through any cap year ending before October 1, 2025 (that is, through cap year 2025).

*E. Trends in Medicare Hospice Utilization*

Since the implementation of the hospice benefit in 1983, and especially within the last decade, there has been substantial growth in hospice utilization. The number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to over 1.3 million in FY 2013. Similarly, Medicare hospice expenditures have risen from $2.8 billion in FY 2000 to an estimated $15.3 billion in FY 2013. 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. However, this increased spending is partly due to an increased average lifetime length of stay for beneficiaries, from 54 days in 2000 to 98.5 days in FY 2013, an increase of 82 percent.

There have also been changes in the diagnosis patterns among Medicare hospice enrollees. Specifically, there were notable increases between 2002 and 2007 in neurologically-based diagnoses, including various dementia diagnoses. Additionally, there have been significant increases in the use of non-specific, symptom-classified diagnoses, such as ''debility'' and ''adult failure to thrive.'' In FY 2013, ''debility'' and ''adult failure to thrive'' were the first and sixth most common hospice diagnoses, respectively, accounting for approximately 14 percent of all diagnoses. Effective October 1, 2014, hospice claims were returned to the provider if ''debility'' and ''adult failure to thrive'' were coded as the principal hospice diagnosis as well as other ICD–9–CM codes that are not permissible as principal diagnosis codes per ICD–9–CM coding guidelines. We reminded the hospice industry that this policy would go into effect and claims would start to be returned October 1, 2014 in the FY 2015 hospice rate update final rule. As a result of this, there has been a shift in coding patterns on hospice claims. For FY 2014, the most common hospice principal diagnoses were Alzheimer's disease, Congestive Heart Failure, Lung Cancer, Chronic Airway Obstruction and Senile Dementia which constituted approximately 32 percent of all claims-reported principal diagnosis codes reported in FY 2014 (see Table 2 below).

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2014

| Rank | ICD–9/Reported principal diagnosis | Count | Percentage |
|---|---|---|---|
| | **Year: FY 2002** | | |
| 1 | 162.9 Lung Cancer | 73,769 | 11 |
| 2 | 428.0 Congestive Heart Failure | 45,951 | 7 |
| 3 | 799.3 Debility Unspecified | 36,999 | 6 |
| 4 | 496 COPD | 35,197 | 5 |
| 5 | 331.0 Alzheimer's Disease | 28,787 | 4 |
| 6 | 436 CVA/Stroke | 26,897 | 4 |
| 7 | 185 Prostate Cancer | 20,262 | 3 |
| 8 | 783.7 Adult Failure To Thrive | 18,304 | 3 |
| 9 | 174.9 Breast Cancer | 17,812 | 3 |
| 10 | 290.0 Senile Dementia, Uncomp. | 16,999 | 3 |
| 11 | 153.0 Colon Cancer | 16,379 | 2 |
| 12 | 157.9 Pancreatic Cancer | 15,427 | 2 |

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2014—Continued

| Rank | ICD–9/Reported principal diagnosis | Count | Percentage |
|---|---|---|---|
| 13 | 294.8 Organic Brain Synd Nec | 10,394 | 2 |
| 14 | 429.9 Heart Disease Unspecified | 10,332 | 2 |
| 15 | 154.0 Rectosigmoid Colon Cancer | 8,956 | 1 |
| 16 | 332.0 Parkinson's Disease | 8,865 | 1 |
| 17 | 586 Renal Failure Unspecified | 8,764 | 1 |
| 18 | 585 Chronic Renal Failure (End 2005) | 8,599 | 1 |
| 19 | 183.0 Ovarian Cancer | 7,432 | 1 |
| 20 | 188.9 Bladder Cancer | 6,916 | 1 |
| **Year: FY 2007** | | | |
| 1 | 799.3 Debility Unspecified | 90,150 | 9 |
| 2 | 162.9 Lung Cancer | 86,954 | 8 |
| 3 | 428.0 Congestive Heart Failure | 77,836 | 7 |
| 4 | 496 COPD | 60,815 | 6 |
| 5 | 783.7 Adult Failure To Thrive | 58,303 | 6 |
| 6 | 331.0 Alzheimer's Disease | 58,200 | 6 |
| 7 | 290.0 Senile Dementia Uncomp. | 37,667 | 4 |
| 8 | 436 CVA/Stroke | 31,800 | 3 |
| 9 | 429.9 Heart Disease Unspecified | 22,170 | 2 |
| 10 | 185 Prostate Cancer | 22,086 | 2 |
| 11 | 174.9 Breast Cancer | 20,378 | 2 |
| 12 | 157.9 Pancreas Unspecified | 19,082 | 2 |
| 13 | 153.9 Colon Cancer | 19,080 | 2 |
| 14 | 294.8 Organic Brain Syndrome NEC | 17,697 | 2 |
| 15 | 332.0 Parkinson's Disease | 16,524 | 2 |
| 16 | 294.10 Dementia In Other Diseases w/o Behav. Dist. | 15,777 | 2 |
| 17 | 586 Renal Failure Unspecified | 12,188 | 1 |
| 18 | 585.6 End Stage Renal Disease | 11,196 | 1 |
| 19 | 188.9 Bladder Cancer | 8,806 | 1 |
| 20 | 183.0 Ovarian Cancer | 8,434 | 1 |
| **Year: FY 2013** | | | |
| 1 | 799.3 Debility Unspecified | 127,415 | 9 |
| 2 | 428.0 Congestive Heart Failure | 96,171 | 7 |
| 3 | 162.9 Lung Cancer | 91,598 | 6 |
| 4 | 496 COPD | 82,184 | 6 |
| 5 | 331.0 Alzheimer's Disease | 79,626 | 6 |
| 6 | 783.7 Adult Failure to Thrive | 71,122 | 5 |
| 7 | 290.0 Senile Dementia, Uncomp. | 60,579 | 4 |
| 8 | 429.9 Heart Disease Unspecified | 36,914 | 3 |
| 9 | 436 CVA/Stroke | 34,459 | 2 |
| 10 | 294.10 Dementia In Other Diseases w/o Behavioral Dist. | 30,963 | 2 |
| 11 | 332.0 Parkinson's Disease | 25,396 | 2 |
| 12 | 153.9 Colon Cancer | 23,228 | 2 |
| 13 | 294.20 Dementia Unspecified w/o Behavioral Dist. | 23,224 | 2 |
| 14 | 174.9 Breast Cancer | 23,059 | 2 |
| 15 | 157.9 Pancreatic Cancer | 22,341 | 2 |
| 16 | 185 Prostate Cancer | 21,769 | 2 |
| 17 | 585.6 End-Stage Renal Disease | 19,309 | 1 |
| 18 | 518.81 Acute Respiratory Failure | 15,965 | 1 |
| 19 | 294.8 Other Persistent Mental Dis.-classified elsewhere | 14,372 | 1 |
| 20 | 294.11 Dementia In Other Diseases w/Behavioral Dist. | 13,687 | 1 |
| **Year: FY 2014** | | | |
| 1 | 331.0 Alzheimer's disease | 128,844 | 9 |
| 2 | 428.0 Congestive heart failure, unspecified | 107,540 | 8 |
| 3 | 162.9 Lung Cancer | 90,689 | 6 |
| 4 | 496 COPD | 79,249 | 6 |
| 5 | 290.0 Senile dementia, uncomplicated | 40,269 | 3 |
| 6 | 429.9 Heart disease, unspecified | 37,129 | 3 |
| 7 | 436 CVA/Stroke | 33,759 | 2 |
| 8 | 294.20 Dementia, unspecified, without behavioral disturbance | 33,329 | 2 |
| 9 | 332.0 Parkinson's Disease | 30,292 | 2 |
| 10 | 153.9 Colon Cancer | 23,634 | 2 |
| 11 | 174.9 Breast Cancer | 23,569 | 2 |
| 12 | 157.9 Pancreatic Cancer | 22,789 | 2 |
| 13 | 185 Prostate Cancer | 22,374 | 2 |
| 14 | 585.6 End stage renal disease | 21,713 | 2 |
| 15 | 294.10 Dementia in conditions classified elsewhere w/o behav disturbance | 19,660 | 1 |

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2002, FY 2007, FY 2013, FY 2014—Continued

| Rank | ICD–9/Reported principal diagnosis | Count | Percentage |
|---|---|---|---|
| 16 | 331.2 Senile degeneration of brain | 18,847 | 1 |
| 17 | 518.81 Acute respiratory failure | 17,624 | 1 |
| 18 | 290.40 Vascular dementia, uncomplicated | 17,318 | 1 |
| 19 | 491.21 Obstructive chronic bronchitis with (acute) exacerbation | 16,168 | 1 |
| 20 | 429.2 Cardiovascular disease, unspecified | 14,305 | 1 |

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

**Source:** FY 2002 and 2007 hospice claims data from the Chronic Conditions Data Warehouse (CCW), accessed on February 14 and February 20, 2013. FY 2013 hospice claims data from the CCW, accessed on June 26, 2014 and FY 2014 hospice claims data from the CCW, accessed on July 6, 2015.

*A. Hospice Payment Reform Research and Analyses*

In 2010, the Congress amended section 1814(i)(6) of the Act with section 3132(a) of the Affordable Care Act. The amendment authorizes the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and for other purposes. The data collected may be used to revise the methodology for RHC and other hospice services (in a budget-neutral manner in the first year), no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. The Secretary is required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment reform options.

Since 2010, we have undertaken efforts to collect the data needed to establish what revisions to the methodology for determining the hospice payment rates may be necessary. Effective April 1, 2014, we began requiring additional information on hospice claims regarding drugs and certain durable medical equipment and effective October 1, 2014, we finalized changes to the hospice cost report to improve data collection on the costs of providing hospice care.[3] In addition, our research contractor, Abt Associates, conducted a hospice literature review; held stakeholder meetings; and developed and maintained an analytic plan, which supports effort towards implementing hospice payment reform. During the stakeholder meetings, attendees articulated concerns of sweeping payment reform changes and encouraged us to consider incremental steps or to use existing regulatory authority to refine the hospice program. We also held five industry technical expert panels (TEPs) via webinar and in-person meetings; consulted with federal hospice experts; provided annual updates on findings from our research and analyses and reform options in the FY 2014 and FY 2015 Hospice Wage Index and Payment Rate Update proposed and final rules (78 FR 48234 and 79 FR 50452); and updated the hospice industry on reform work through Open Door Forums, industry conferences and academic conferences.[4] We have taken into consideration the recommendations from MedPAC on reforming hospice payment, as articulated in the MedPAC Reports to Congress since 2009. The MedPAC recommendations and research provided a foundation for our development of an analytic plan and additional payment reform concepts. Furthermore, MedPAC participated in post-TEP meetings with other federal hospice experts. These meetings provided valuable feedback regarding the TEP's comments and discussed potential research and analyses to consider for hospice payment reform.

The FY 2012 Hospice Wage Index final rule (76 FR 47324) noted our collaboration with the Assistant Secretary of Planning and Evaluation (ASPE) to develop analyses that were used to inform our research efforts. The results from such analyses were used by Abt Associates to facilitate discussion, in 2012, of potential payment reform options and to guide the identification of topics for further analysis. In early 2014, we began working with Acumen, LLC, using real-time claims data, to monitor the vulnerabilities identified in the 2013 and 2014 Abt Associates' Hospice Payment Reform Technical Reports. On September 18, 2014, the IMPACT Act, mandated that the Centers for Medicare & Medicaid (CMS) undertake additional hospice monitoring and oversight activities. As noted previously, the IMPACT Act requires CMS to survey hospices at least as frequently as every 3 years for the next 10 years and review medical records of hospice beneficiaries on the hospice benefit for 180 days or greater as specified by the Secretary. CMS is actively engaged in cross-agency collaboration to meet the intent of the IMPACT Act to increase monitoring and oversight of hospice providers.

The majority of the research and analyses conducted by CMS and summarized in this rule were based on analyses of FY 2013 Medicare claims and cost report data conducted by our research contractor, Abt Associates, unless otherwise specified. In addition, we cite research and analyses, conducted by Acumen, LLC that are based on real-time claims data from the Integrated Data Repository (IDR). In the sections below, analysis conducted on pre-hospice spending, non-hospice spending for hospice beneficiaries during a hospice election, and live discharge rates highlight potential vulnerabilities of the Medicare hospice benefit.

1. Pre-Hospice Spending

In 1982, the Congress introduced hospice into the Medicare program as an alternative to aggressive treatment at the end of life. During the development of the benefit, multiple testimonies from industry leaders and hospice families were heard and it was reported that hospices provided high-quality, compassionate and humane care while also offering a reduction in Medicare costs.[5] Additionally, a Congressional Budget Office (CBO) study asserted that hospice care would result in sizable savings over conventional hospital care.[6] Those savings estimates were based on a comparison of spending in

[3] CMS Transmittal 2864, ''Additional Data Reporting Requirements for Hospice claim''. Available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864P.pdf.*

[4] *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Project-Background.pdf.*

[5] Subcommittee of Health of the Committee of Ways and Means, House of Representatives, March 25, 1982.

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

the last 6 months of life for a cancer patient not utilizing hospice care versus the cost of hospice care for the 6 months preceding death.[7] The original language for § 1814(i) of the Act (prior to August, 29, 1983) set the hospice aggregate cap amount at 40 percent of the average Medicare per capita expenditure amount for cancer patients in the last 6 months of life. When the hospice benefit was created, the average lifetime length of stay for a hospice patient was between 55 and 75 days. Since the implementation of the Medicare hospice benefit, the principal diagnosis for patients electing the hospice benefit has changed from primarily cancer diagnoses in 1983 to primarily non-cancer diagnoses in FY 2014.[8] Alzheimer's disease and Congestive Heart Failure (CHF) were the most reported principal diagnoses comprising 17 percent of all diagnoses reported (see Table 2 in section II.E) in FY 2014.

Analysis was conducted to evaluate pre-hospice spending for beneficiaries who used hospice and who died in FY 2013. To evaluate pre-hospice spending, we calculated the median daily Medicare payments for such beneficiaries for the 180 days, 90 days, and 30 days prior to electing hospice care. We then categorized patients according to the principal diagnosis reported on the hospice claim. The analysis revealed that for some patients, the Medicare payments in the 180 days prior to the hospice election were lower than Medicare payments associated with hospice care once the benefit was elected (see Table 3 and Figure 1 below). Specifically, median Medicare spending for a beneficiary with a diagnosis of Alzheimer's disease, non-Alzheimer's dementia, or Parkinson's in the 180 days prior to hospice admission (about 20 percent of patients) was $66.84 per day compared to the daily RHC rate of $153.45 in FY 2013 (see Table 3 below). Closer to the hospice admission, the median Medicare payments per day increase, as would be expected as the patient approaches the end of life and patient needs intensify. However, 30 days prior to a hospice election, median Medicare spending was $105.24 for patients with Alzheimer's disease, non-Alzheimer's dementia, or Parkinson's. In contrast, the median Medicare payments prior to hospice election for patients with a principal hospice diagnosis of cancer were $143.56 in the 180 days prior to hospice admission and increased to $289.85 in the 30 days prior to hospice admission. The average length of stay for hospice elections where the principal diagnosis was reported as Alzheimer's disease, non-Alzheimer's Dementia, or Parkinson's is greater than patients with other diagnoses, such as cancer, Cerebral Vascular Accident (CVA)/stroke, chronic kidney disease, and Chronic Obstructive Pulmonary Disease (COPD). For example, the average lifetime length of stay for an Alzheimer's, non-Alzheimer's Dementia, or Parkinson's patient in FY 2013 was 119 days compared to 47 days for patients with a principal diagnosis of cancer (or in other words, 150 percent longer).

TABLE 3—MEDIAN PRE-HOSPICE DAILY SPENDING ESTIMATES AND INTERQUARTILE RANGE BASED ON 180, 90, AND 30 DAY LOOK-BACK PERIODS PRIOR TO INITIAL HOSPICE ADMISSION WITH ESTIMATES OF AVERAGE LIFETIME LENGTH OF STAY (LOS) BY PRIMARY DIAGNOSIS AT HOSPICE ADMISSION, FY 2013

| | Estimates of daily non-hospice medicare spending prior to first hospice admission | | | | | | | | | Mean lifetime LOS |
|---|---|---|---|---|---|---|---|---|---|---|
| | 180 day look-back | | | 90 day look-back | | | 30 day look-back | | | |
| | 25th Pct. | Median | 75th Pct. | 25th Pct. | Median | 75th Pct. | 25th Pct. | Median | 75th Pct. | |
| All Diagnoses | $47.04 | $117.73 | $240.73 | $55.75 | $157.89 | $337.97 | $57.66 | $266.84 | $545.44 | 73.8 |
| Alzheimer's, Dementia, and Parkinson's | 23.39 | 66.84 | 162.60 | 23.06 | 82.00 | 220.12 | 21.02 | 105.24 | 368.30 | 119.3 |
| CVA/Stroke | 56.18 | 116.86 | 239.30 | 82.32 | 170.40 | 352.74 | 150.21 | 352.41 | 622.23 | 47.4 |
| Cancers | 62.81 | 143.56 | 265.58 | 78.30 | 188.08 | 360.92 | 81.52 | 289.85 | 569.67 | 47.1 |
| Chronic Kidney Disease | 94.78 | 217.46 | 402.10 | 126.41 | 293.18 | 541.41 | 199.01 | 466.25 | 820.78 | 27.3 |
| Heart (CHF and Other Heart Disease) | 61.28 | 135.48 | 255.53 | 80.62 | 186.52 | 364.24 | 101.80 | 325.15 | 588.50 | 77.2 |
| Lung (COPD and Pneumonias) | 65.53 | 142.78 | 272.13 | 90.68 | 201.02 | 401.12 | 126.51 | 367.68 | 685.17 | 67.5 |
| All Other Diagnoses | 36.00 | 99.80 | 222.25 | 39.45 | 132.88 | 316.15 | 38.96 | 213.84 | 504.57 | 85.3 |

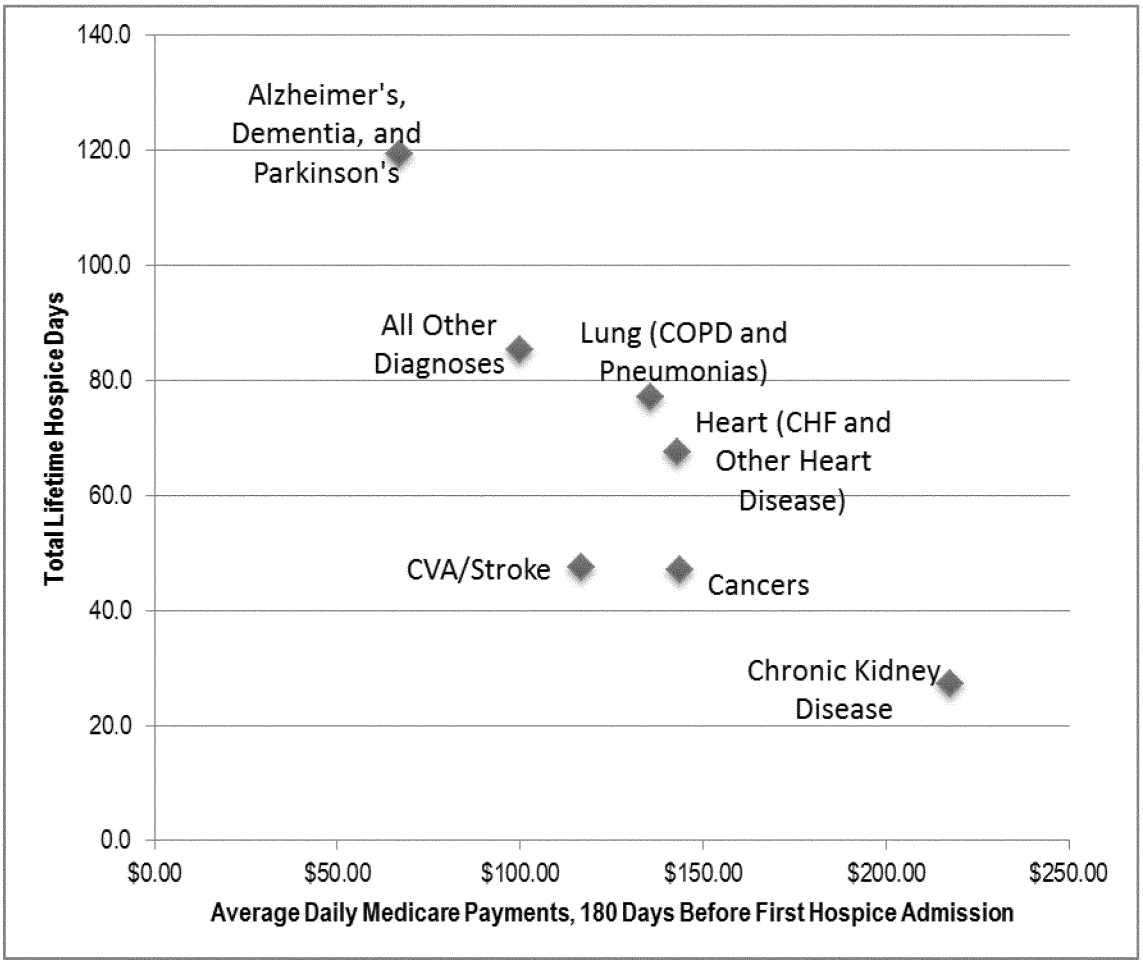
**Source:** All Medicare Parts A, B, and D claims for FY 2013 from the Chronic Conditions Data Warehouse (CCW) retrieved March, 2015.

**Note(s):** Estimates drawn from FY2013 hospice decedents who were first-time hospice admissions, ages 66+ at hospice admission, admitted since 2006, and not enrolled in Medicare Advantage prior to admission. All payments are inflation-adjusted to September 2013 dollars using the Consumer Price Index (Medical Care; All Urban Consumers).

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

[8] Connor, S. (2007). Development of Hospice and Palliative Care in the United States. OMEGA. 56(1), 89–99. doi:102190/OM.5.1.h

Figure 1: Average Pre-Hospice Daily Spending Estimates based on a180-day Look-Back Period Prior to Initial Hospice Admission with Estimates of Lifetime Length of Stay by Primary Diagnosis at Hospice Admission, FY 2013




In the FY 2014 Hospice Wage Index and Payment Rate Update proposed and final rules (78 FR 27843 and 78 FR 48272), we discussed whether a case-mix system could be created in future refinements to differentiate hospice payments according to patient characteristics. While we do not have the necessary data on the hospice claim form at this time to conduct more thorough research to determine whether a case-mix system is appropriate, analyzing pre-hospice spending was undertaken as an initial step in determining whether patients required different resource needs prior to hospice based on the principal diagnosis reported on the hospice claim. Table 3 and Figure 1 above indicate that hospice patients with the longest length of stay had lower pre-hospice spending relative to hospice patients with shorter lengths of stay. These hospice patients tend to be those with neurological conditions, including those with Alzheimer's disease, other related dementias and Parkinson's disease. Typically, these conditions are associated with longer disease trajectories, progressive loss of functional and cognitive abilities, and more difficult prognostication.

Research has shown that the majority of dementia patients are cared for at home, leading to increased informal care costs that put an economic burden on families rather than on healthcare systems.[9] Additionally, research using the National Long-Term Care Survey (NLCS) merged with Medicare claims; found that patients with Alzheimer's disease and related conditions do not have higher Medicare expenditures over the last 5 years of their life compared to non-demented elderly.[10] Some researchers have measured whether hospice care reduces overall Medicare costs at the end of life. Research conducted by the RAND Corporation and published in the Annals of Internal Medicine in February of 2004 found that ''adjusted mean [Medicare] expenditures were 4.0 percent higher overall among hospice enrollees than among non-enrollees. Adjusted mean [Medicare] expenditures were 1 percent lower for hospice enrollees with cancer than for patients with cancer who did not use hospice. Savings were highest (7 percent to 17 percent) among enrollees with lung cancer and other very aggressive types of cancer diagnosed in the last year of life. [Medicare] Expenditures for hospice enrollees without cancer were 11 percent higher than for non-enrollees, ranging from 20

[9] Schaller, S., Mauskopf, J., Kriza, C., Wahlster, P., Kolominsky-Rabas, P. (2015). The main cost drivers in dementia: a systematic review. International Journal of Geriatric Psychiatry. 15, 111–129. doi: 10.1002/gps.4198.

[10] Ayyagari, P., M. Salm, and F. Sloan. 2008. ''Effects of Diagnosed Dementia on Medicare and Medicaid Program Costs.'' Inquiry 44 (Winter 2007/2008): 481–94. Lamb, V., F. Sloan, and A. Nathan. 2008. ''Dementia and Medicare at Life's End.'' Health Services Research 43 (2): 714–32.

percent to 44 percent for patients with dementia and 0 percent to 16 percent for those with chronic heart failure or failure of most other organ systems.'' [11] While analyses examining pre-hospice spending for hospice patients according to their diagnosis reported on the hospice claim has some limitations, it does show that, depending on the type of research study design selected, different conclusions can be drawn regarding the effect of Alzheimer's disease and dementia on medical care costs.[12] An article was released in May of 2015 by the New England Journal of Medicine titled ''Changes in Medicare Costs with the Growth of Hospice Care in Nursing Homes,'' that examined the impact of hospice use for nursing home residents on end of life costs. This article found that between 2004 and 2009, the expansion of hospice was associated with a mean net increase in Medicare expenditures of $6,761 (95 percent confidence interval, 6,335 to 7,186), reflecting greater additional spending on hospice care ($10,191) than reduced spending on hospital and other care ($3,430). The growth in hospice care for nursing home residents was associated with less aggressive care near death but at an overall increase in Medicare expenditures.'' [13]

2. Non-Hospice Spending for Hospice Beneficiaries During an Election

When a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the terminal illness and related conditions, except for services provided by the designated hospice and the attending physician (as described in section II of this rule). However, Medicare payment is allowed for covered Medicare items and services that are unrelated to the terminal illness and related conditions (that is, the terminal prognosis). When a hospice beneficiary receives items or services unrelated to the terminal illness and related conditions from a non-hospice provider, that provider can bill Medicare for the items or services, but must include on the claim a GW (service not related to the hospice patient's terminal condition) modifier (if billed on a professional claim),[14] or condition code 07 (if billed on an institutional claim).[15] Prescription Drug Events (PDEs) unrelated to the terminal prognosis for which hospice beneficiaries are receiving hospice care are billed to Part D and do not require a modifier or a condition code. We reported initial findings on CY 2012 non-hospice spending during a hospice election in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452). This section updates our analysis of non-hospice spending during a hospice election using FY 2013 data.

For FY 2013, we found that Medicare paid $694.1 million for Part A and Part B items or services while a beneficiary was receiving hospice care. The $694.1 million paid for Part A and Part B items or services was for durable medical equipment (6.4 percent), inpatient care (care in long- term care hospitals, inpatient rehabilitation facilities, acute care hospitals; 28.6 percent), outpatient Part B services (16.6 percent), other Part B services (also known as physician, practitioner and supplier claims, such as labs and diagnostic tests, ambulance transports, and physician office visits; 38.8 percent), skilled nursing facility care (5.3 percent), and home health care (4.3 percent). Part A and Part B non-hospice spending occurred mostly for hospice beneficiaries who were at home (56.0 percent). We also found that on hospice service days in which non-hospice spending occurred, 25.7 percent of hospice beneficiaries were in a nursing facility, 1.9 percent were in an inpatient setting, 15.1 percent were in an assisted living facility, and 1.3 percent were in other settings. Although the average daily rate of expenditures outside the hospice benefit was $7.65, we found geographic differences where beneficiaries receive care. The highest rates per day occurred for hospice beneficiaries residing in West Virginia ($13.74), Delaware ($12.76), Mississippi ($12.31), South Florida ($12.24), and Texas ($12.10).

Table 4 below details the various components of Part D spending for patients receiving hospice care. The portion of the $439.5 million total Part D spending which was paid by Medicare is the sum of the Low Income Cost-Sharing Subsidy and the Covered Drug Plan Paid Amount, or $347.1 million.

TABLE 4—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES' FY 2013 DRUGS RECEIVED THROUGH PART D

| Component | FY 2013 expenditures |
|---|---|
| (Patient Pay Amount) | $50,871,517 |
| (Low Income Cost-Sharing Subsidy) | 116,890,745 |
| (Other True Out-of Pocket Amount) | 2,125,071 |
| (Patient Liability Reduction due to Other Payer Amount) | 6,678,561 |
| (Covered Drug Plan Paid Amount) | 230,216,153 |
| (Non-Covered Plan Paid Amount | 28,733,518 |
| (Six Payment Amount Totals) | 435,515,566 |
| (Unknown/Unreconciled) | 3,945,667 |
| (Gross Total Drug Costs, Reported) | 439,461,233 |

**Source:** Abt Associates analysis of 100% FY 2013 Medicare Claim Files. For more information on the components above and on Part D data, go to the Research Data Assistance Center's (ResDAC's) Web site at: *http://www.resdac.org/.*

Non-hospice Medicare expenditures occurring during a hospice election in FY 2013 were $694.1 million for Parts A and B plus $347.1 million for Part D spending, or approximately $1 billion dollars total. This figure is comparable to the estimated $1 billion MedPAC reported during its December 2013 public meeting.[16] Associated with this $1 billion in Medicare spending were cost sharing liabilities such as co-payments and deductibles that beneficiaries incurred. Hospice beneficiaries had $132.5 million in cost-sharing for items and services that were billed to Medicare Parts A and B, and $50.9 million in cost-sharing for drugs that were billed to Medicare Part D, while they were in a hospice election. In total, this represents an FY 2013 beneficiary liability of $183.4 million for Parts A, B, and D items or services provided to hospice beneficiaries during a hospice election. Therefore, the total non-hospice costs paid by Medicare or beneficiaries for items or services provided to hospice beneficiaries during a hospice election were over $1.2 billion in FY 2013.

In a recent report, the HHS Office of Inspector General (OIG) identified instances where Medicare may be

[11] *http://www.rand.org/pubs/external_publications/EP20040207.html.* Accessed on April 23, 2015.

[12] Yang, Z., Zhang, K., Lin, P., Clevenger, C., & Atherly, A. (2012). A Longitudinal Analysis of the Lifetime Cost of Dementia. Health Services Research, 47(4), 1660–1678. doi:10.1111/j.1475–6773.2011.01365.x.

[13] Gozalo, P., Plotske, M., Mor, V., Miller, S. & Teno, J. (2015). Changes in Medicare Costs with the Growth of Hospice Care in Nursing Homes. New England Journal of Medicine, 372:19, 1823–1831.

[14] Medicare Claims Processing Manual, Chapter 11-Processing Hospice Claims, Section 30.4-Claims from Medicare Advantage Organizations, B-Billing of Covered Services. *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf.*

[15] Medicare Claims Processing Manual, Chapter 11-Processing Hospice Claims, Section 30.3-Data Required on the Institutional Claim to Medicare Contractors, Conditions Codes. *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf.*

[16] MedPAC, ''Assessing payment adequacy and updating payments: hospice services'', December 13 2013. Available at: *http://www.medpac.gov/documents/december-2013-meeting-transcript.pdf.*

paying twice under Part D for drugs that should be provided by the hospice as part of the plan of care.[17] To assist CMS in identifying and evaluating instances where drugs, supplies, durable medical equipment (DME), and Part B services provided to hospice patients appear to be related to the principal diagnosis reported on the hospice claim, but were billed separately to other parts of the Medicare program, Acumen, LLC developed case studies that were reviewed and evaluated by CMS clinical staff.[18] Although hospice beneficiaries are allowed to continue receiving care outside the hospice benefit for conditions that are unrelated to the terminal illness and related conditions (that is, unrelated to the terminal prognosis), § 418.56(c) requires hospices to provide all services necessary for the palliation and management of the terminal illness and related conditions.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Across Terminal Conditions

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) products whose use was initiated during a hospice stay are likely related to the terminal prognosis. Table 5 and 6 below summarizes total concurrent billing for DMEPOS products by Berenson-Eggers Types of Service (BETOS) categories and concurrent DME billing by the top 20 principal diagnoses as reported on hospice claims in CY 2013.[19] These diagnoses comprised 2.3 million hospice stays, and accounted for $27.1 million in total concurrent spending for DME products. This amount does not include spending for DME rental products that beneficiaries began using prior to a hospice stay.

TABLE 5—CONCURRENT PAYMENTS FOR ALL DME USE INITIATED DURING A HOSPICE STAY BY BETOS CATEGORY, CY 2013

| DMEPOS BETOS category | Total payment for related DME |
|---|---|
| Hospital Beds | $943,731 |
| Wheelchairs | 2,295,038 |
| Oxygen and Supplies | 2,412,281 |
| Orthotics and Prosthetics | 4,400,353 |
| Medical/Surgical Supplies | 7,467,616 |
| Other DME | 9,585,003 |
| Total | 27,104,022 |

TABLE 6—CONCURRENT PAYMENTS FOR ALL DME USE INITIATED DURING A HOSPICE STAY BY TOP 20 PRINCIPAL DIAGNOSIS REPORTED ON HOSPICE CLAIM, CY 2013

| Principal diagnosis | Total payment for related DME |
|---|---|
| Heart failure | $3,365,348 |
| Malignant neoplasm of trachea, bronchus, and lung | 1,519,514 |
| Other cerebral degenerations | 2,979,399 |
| Other organic psychotic conditions (chronic) | 2,540,146 |
| Chronic airways obstruction, not elsewhere classified | 2,610,628 |
| Senile and presenile organic psychotic conditions | 2,868,760 |
| Other ill-defined and unknown causes of morbidity and mortality | 2,349,855 |
| Ill-defined descriptions and complications of heart disease | 1,584,522 |
| Acute but ill-defined cerebrovascular disease | 1,092,772 |
| Other diseases of lung | 412,501 |
| Chronic renal failure | 415,800 |
| Symptoms concerning nutrition, metabolism, and development | 1,390,685 |
| Malignant neoplasm of pancreas | 297,573 |
| Malignant neoplasm of female breast | 486,019 |
| Malignant neoplasm of colon | 521,690 |
| Parkinson's disease | 955,390 |
| Malignant neoplasm of prostate | 312,754 |
| Late effects of cerebrovascular disease | 559,253 |
| Other forms of chronic ischemic heart disease | 670,947 |
| Malignant neoplasm of liver and intrahepatic bile ducts | 170,470 |

We noted that hospice beneficiaries with hospice claims-reported principal diagnoses of chronic airway obstruction, congestive heart failure, cerebral degeneration and lung cancer were receiving services clinically indicated and recommended for these conditions outside of the hospice benefit, which is in violation of requirements regarding the Medicare hospice benefit. This could be attributed to hospices incorrectly classifying conditions as unrelated and referring patients to non-hospice providers, not communicating and coordinating the care and services needed to manage the needs of the hospice beneficiary, or deliberately, to avoid costs. The case studies below are focused on four of the most commonly reported principal hospice diagnoses on hospice claims (see Table 2 in section II.E) based on clinical guidelines as described for each principal hospice diagnosis.

[17] *oig.hhs.gov/oas/region6/61000059.pdf* ''Medicare Could Be Paying Twice for Prescriptions For Beneficiaries in Hospice.''

[18] The case studies were developed using CY 2013 claims data for only those beneficiaries with Parts A, B and D coverage throughout their hospice. In identifying services that overlapped with a hospice election, we used two methods. The first method identified a match between the first three diagnosis codes of the hospice claim and the diagnosis codes of the overlapping services in the Part A, Part B, and Part D claim for the same beneficiary. The second method identified a match between the hospice diagnoses and the diagnosis codes of the overlapping services in the Part A, Part B and Part D based on a diagnosis code on the overlapping claim and any diagnosis on the hospice claim mapping to the same Healthcare Cost and Utilization Project (HCUP).

[19] DMEPOS HCPCS codes are summarized by Berenson-Eggers Types of Service (BETOS) categories. BETOS categories were developed by the American Medical Association (AMA) and aggregate HCPCS codes into clinically coherent groups.

Malignant Neoplasm of the Trachea, Bronchus, and Lung

Malignant neoplasm of the trachea, bronchus, and lung (or lung cancer) is defined by ICD–9 diagnosis codes beginning with 162 and describes malignant cancers affecting various part of the pulmonary system. Symptoms for this class of conditions may include chronic and worsening cough, shortness of breath, chest pain, metastatic bone pain, and anorexia and weight loss. Clinical practice guidelines for end-stage cancer recommend treatment and management of refractory symptoms including pain, mucositis, dyspnea, fatigue, depression and anorexia through the use of pharmacological interventions including nonsteroidal anti-inflammatories, corticosteroids, opioids and antidepressants.[20] Additionally, evidence shows that palliative chemotherapy and radiotherapy can provide symptom relief from bone and brain metastasis.[21] Recommended interventions for dyspnea include treatment of the underlying reason such as, thoracentesis for pleural effusion, bronchodilators and systemic corticosteroids for inflammation and secretions, and supportive measures such supplemental oxygen, opioids and anxiolytics to decrease the sensation of breathlessness.[22]

Our assessment of concurrently billed Part D drugs included 89,925 stays for beneficiaries with ICD–9 code 162 listed as a primary diagnosis on the hospice claim. Our assessment of concurrently billed Part B services included 153,199 stays. In CY 2013, concurrent billing for all services related this terminal condition comprised $3.4 million. Table 7 below summarizes concurrent payments for services that were potentially related to this class of conditions. Part D drugs that should have been covered under the hospice benefit for the treatment of this condition accounted for $2.1 million. DME services that were billed during hospice stays related to this condition during the same time cost $640,166. Concurrent services provided in Part B institutional settings accounted for $591,772.

TABLE 7—CONCURRENT PAYMENTS FOR SERVICES PROVIDED TO HOSPICE BENEFICIARIES WITH MALIGNANT NEOPLASM OF THE TRACHEA, BRONCHUS, AND LUNG, CY 2013

| Type of service | Description | Total payment |
|---|---|---|
| Drugs/Part D | Common Palliative Drugs | $851,639 |
| Drugs/Part D | Anti-neoplastics (chemotherapy) | 1,321,507 |
| DME | Oxygen Equipment and Supplies | 454,068 |
| DME | Hospital Beds | 47,781 |
| DME | Wheelchairs | 138,316 |
| Part B Inst | Diagnostic Imaging | 341,601 |
| Part B Inst | Radiation | 250,171 |
| Total | | 3,405,083 |

Chronic Airway Obstruction

Chronic airway obstruction is defined by ICD–9 diagnosis codes beginning with 496 and includes chronic lung disease with unspecified cause, and is characterized by inflammation of the lungs and airways. Typical symptoms of these pulmonary diseases include increasing and disabling shortness of breath, labored breathing, increased coughing, increased heart rate, decreased functional reserve, increased infections and unintentional, progressive weight loss. Evidence-based practice supports the benefits of oral opioids, neuromuscular electrical stimulation, chest wall vibration, walking aids, respiratory assist devices and pursed-lip breathing in the management of dyspnea in the individual patient with advanced COPD.[23] Oxygen is recommended for COPD patients with resting hypoxemia for symptomatic benefit.[24] Additionally, clinical practice guidelines recommend inhaled bronchodilators, systemic corticosteroids, and pulmonary physiotherapy for the management of COPD exacerbations.[25] Analysis conducted by Acumen, LLC, shows concurrently billed Part D drugs included 130,283 stays for beneficiaries with ICD–9 code 469 listed as a primary diagnosis on the hospice claim. Additionally, concurrently billed Part B services included 198,098 such stays. Table 8 below summarizes concurrent payments for services that are potentially related to this class of conditions. In CY 2013, concurrent billing for all services related this terminal condition comprised $10.4 million. Part D drugs that should have been covered under the hospice benefit for the treatment of this condition accounted for $8.6 million. DME services that were billed during hospice stays related to this condition during the same time amounted to $1.2 million dollars.[26] Finally, concurrent services provided in Part B institutional settings accounted for $605,110.

[20] Qaseem A, Snow V, Shekelle P, Casey DE, Cross JT, Owens DK, et al. Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: A Clinical Practice Guideline from the American College of Physicians. Ann Intern Med. 2008;148:141–146. doi:10.7326/0003–4819–148–2–200801150–00009.

[21] Palliative care in lung cancer*: accp evidence-based clinical practice guidelines (2nd edition) Kvale PA, Selecky PA, Prakash US. Chest. 2007;132(3_suppl):368S–403S.

[22] Ibid.

[23] DD Marciniuk, D Goodridge, P Hernandez, et al. (2011). Canadian Thoracic Society COPD Committee Dyspnea Expert Working Group. Managing dyspnea in patients with advanced chronic obstructive pulmonary disease: A Canadian Thoracic Society clinical practice guideline. Canadian Respiratory Journal. 18(2), 1–10.

[24] Ibid.

[25] National Clinical Guideline Centre for Acute and Chronic Conditions. Chronic obstructive pulmonary disease. Management of chronic obstructive pulmonary disease in adults in primary and secondary care. London (UK): National Institute for Health and Clinical Excellence (NICE); 2010 Jun. 61 p. (Clinical guideline; no. 101). Retrieved from the National Guideline Clearinghouse on February 19, 2015. *http://www.guideline.gov/*.

[26] DMEPOS HCPCS codes are summarized by Berenson-Eggers Types of Service (BETOS) categories. BETOS categories were developed by the American Medical Association (AMA) and aggregate HCPCS codes into clinically coherent groups.

TABLE 8—CONCURRENT PAYMENTS FOR SERVICES PROVIDED TO HOSPICE BENEFICIARIES WITH CHRONIC AIRWAY OBSTRUCTION, CY 2013

| Type of service | Description | Total payment |
|---|---|---|
| Drugs/Part D | Common Palliative Drugs [27] | $1,757,326 |
| Drugs/Part D | Antiasthmatics & Bronchodilators | 6,545,089 |
| Drugs/Part D | Corticosteroids | 141,179 |
| Drugs/Part D | Respiratory Agents | 148,793 |
| DME | Oxygen Equipment and Supplies [28] | 525,276 |
| DME | Hospital Beds | 480,854 |
| DME | Wheelchairs | 196,692 |
| Part B Institutional | Diagnostic Imaging | 605,110 |
| Total | | 10,400,319 |

Cerebral Degeneration

Cerebral degeneration is defined by ICD–9 diagnosis codes beginning with 331, and includes conditions such as Alzheimer's disease and Reye's syndrome. These conditions are typically characterized by a progressive loss of cognitive function with symptoms including the loss of memory and changes in language ability, behavior, and personality. Additionally, as these cerebral degenerations progress, other clinical manifestations occur such as dysphagia, motor dysfunction, impaired mobility, increased need for activities of daily living assistance, urinary and fecal incontinence, weight loss and muscle wasting. Individuals with these conditions are also at increased risk for aspiration, falls, pneumonias, decubitus ulcers and urinary tract infections. Clinical practice guidelines for the treatment of cerebral degenerative conditions includes pharmacological interventions including Angiotensin Converting Enzyme inhibitors, memantine or combination therapy depending on severity of disease, as well as antidepressants, antipsychotics, psychostimulants, mood stabilizers, benzodiazepines and neuroleptics, depending on behavioral manifestations. Non-pharmacological interventions recommended include mental, behavioral and cognitive therapy, speech language pathology to address swallowing issues, and other interventions to treat and manage manifestations including pressure ulcers, cachexia and infections.[29]

Our assessment of concurrently billed Part D drugs included 208,346 stays for beneficiaries with ICD–9 code 331 listed as a primary diagnosis on the hospice claim. Our assessment of concurrently billed Part B services included 318,044 stays. In CY 2013, concurrent billing for all services related to this principal diagnosis comprised $11.2 million. Table 9 below summarizes concurrent payments for services that are potentially related to this class of conditions. Part D drugs that should have been covered under the hospice benefit for the treatment of this condition accounted for $10.3 million. Concurrently billed DME products that were related this condition cost Medicare an additional $390,476. Concurrent services provided in Part B institutional settings accounted for $496,790.

TABLE 9—CONCURRENT PAYMENTS FOR SERVICES PROVIDED TO HOSPICE BENEFICIARIES WITH CEREBRAL DEGENERATION, CY 2013

| Type of service | Description | Total payment |
|---|---|---|
| Drugs/Part D | Common Palliative Drugs | $1,184,005 |
| Drugs/Part D | Antipsychotic/Antimanic Agents | 2,336,504 |
| Drugs/Part D | Psychotherapeutic & Neurological Agents | 6,752,270 |
| DME | Hospital Beds | 138,249 |
| DME | Wheelchairs | 252,228 |
| Part B Inst. | Diagnostic Imaging | 496,790 |
| Total | | 11,160,046 |

Congestive Heart Failure

CHF is defined by ICD–9 diagnosis codes beginning with 428. CHF is characterized by symptoms such as shortness of breath, edema, diminished endurance, angina, productive cough and fatigue. For the management of congestive heart failure, clinical practice guidelines recommend pharmacological interventions including beta blockers, angiotensin converting enzyme inhibitors, angiotensin receptor blockers, diuretics, anti-platelets, anti-coagulants and digoxin, depending on symptomology and response or nonresponse to other treatments.[30] Nonpharmacological interventions recommended include continuous positive airway pressure and supplemental oxygen for those with coexisting pulmonary disease.[31]

[27] Includes all analgesics, anxiolytics, antiemetics, and laxatives. These four drug types are considered ''nearly always covered under the hospice benefit'' and as such are rarely expected to be billed separately during a hospice stay.

[28] For COPD, we also include respiratory assist devices (RADs) in this category.

[29] Development Group of the Clinical Practice Guideline [trunc]. Clinical practice guideline on the comprehensive care of people with Alzheimer's disease and other dementias. Barcelona (Spain): Agency for Health Quality and Assessment of Catalonia (AQuAS); 2010. 499 p. Retrieved from the National Guideline Clearinghouse on February 19, 2015. *http://www.guideline.gov/*.

[30] Scottish Intercollegiate Guidelines Network (SIGN). Management of chronic heart failure. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2007 Feb. 53 p. (SIGN publication; no. 95).

[31] Lindenfeld J, Albert NM, Boehmer JP, Collins SP, Ezekowitz JA, Givertz MM, Klapholz M, Moser

Our assessment of concurrently billed Part D drugs included 158,220 stays for beneficiaries with ICD–9 code 428 listed as a primary diagnosis on the hospice claim. Our assessment of concurrently billed Part B services included 256,236 stays. In CY 2013, concurrent billing for all services related this terminal condition comprised $5.8 million. Table 10 below summarizes concurrent payments for services that are potentially related to this class of conditions. Part D drugs that should have been covered under the hospice benefit for the treatment of this condition accounted for $3.8 million. DME services that were billed during hospice stays related to this condition during this time cost $843,534. Concurrent services provided in Part B institutional settings accounted for $1.2 million.

TABLE 10—CONCURRENT PAYMENTS FOR SERVICES PROVIDED TO HOSPICE BENEFICIARIES WITH CONGESTIVE HEALTH FAILURE, CY 2013

| Type of service | Description | Total payment |
|---|---|---|
| Drugs/Part D | Common Palliative Drugs | $1,229,748 |
| Drugs/Part D | Diuretics | 334,700 |
| Drugs/Part D | Beta Blockers | 363,480 |
| Drugs/Part D | Anti-hypertensives | 584,799 |
| Drugs/Part D | Anti-anginal Agents | 468,333 |
| Drugs/Part D | Cardiovascular Agents—Misc | 799,605 |
| Drugs/Part D | Vasopressors | 43,496 |
| DME | Oxygen Equipment and Supplies | 471,376 |
| DME | Hospital Beds | 96,219 |
| DME | Wheelchairs | 275,940 |
| Part B Inst | Diagnostic Imaging | 690,726 |
| Part B Inst | EKGs | 72,933 |
| Part B Inst | Cardiac Devices | 242,819 |
| Part B Inst | Diagnostic Clinical Labs | 79,999 |
| Part B Prof | Diagnostic Clinical Labs | 64,698 |
| Total | | 5,818,871 |

Our regulations at § 418.56(c) require that hospices provide all services necessary for the palliation and management of the terminal illness and related conditions. We have discussed recommended evidence-based practice clinical guidelines for the hospice claims-reported principal diagnoses mentioned in this section. However, this analysis reveals that these recommended practices are not always being covered under the Medicare hospice benefit. We believe the case studies in this section highlight the potential systematic unbundling of the Medicare hospice benefit by some providers and may be valuable analysis to inform policy stakeholders.

3. Live Discharge Rates

Currently, federal regulations allow a patient who has elected to receive Medicare hospice services to revoke their hospice election at any time and for any reason. The revocation shall act as a waiver of the right to have payment made for any hospice care benefits for the remaining time in such period. The patient may, at a subsequent time, re-elect to receive hospice coverage for additional hospice election periods if he or she is eligible to receive them (§ 418.28(c)(3) and § 418.24(e)). During the time period between revocation/discharge and the re-election of the hospice benefit, Medicare coverage would resume for those Medicare benefits previously waived. A revocation can only be made by the beneficiary, in writing, that he or she is revoking the hospice election; and must indicate the effective date of the revocation. A hospice cannot ''revoke'' a beneficiary's hospice election, nor is it appropriate for hospices to encourage, request or demand that the beneficiary revoke his or her hospice election. Like the hospice election, a hospice revocation is to be an informed choice based on the beneficiary's goals, values and preferences for the services they wish to receive.

Federal regulations only provide limited opportunity for a Medicare hospice provider to 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 automatically or routinely discharge the patient at its discretion, even if the care may be costly or inconvenient. 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 patients and their families to revoke the hospice election at any time. On July 1, 2012, we began collecting discharge information on the claim to capture the reason for all types of discharges which includes, death, revocation, transfer to another hospice, moving out of the hospice's service area, discharge for cause, or due to the patient no longer being considered terminally ill (that is, no longer qualifying for hospice services). Based upon the additional discharge information, Abt Associates, our research contractor performed analysis on FY 2013 claims to identify those beneficiaries who were discharged alive. The details of this analysis will be reported in the 2015 technical report and will be made available on the Hospice Center Web page. Several key conclusions from the 2015 technical report are included below. In order to better understand the characteristics of hospices with high live discharge rates, we examined the aggregate cap status, skilled visit intensity; average lengths of stay; and non-hospice spending rates per beneficiary.

Between 2000 and 2013, the overall rate of live discharges increased from 13.2 percent in 2000 to 18.3 percent in 2013. Among hospices with 50 or more

DK, Rogers JG, Starling RC, Stevenson WG, Tang WHW, Teerlink JR, Walsh MN. Executive Summary: HFSA 2010 Comprehensive Heart Failure Practice Guideline. J Card Fail 2010;16:475e539.

discharges (discharged alive or deceased), there is significant variation in the rate of live discharge between the 10th and 90th percentiles (see Table 11 below). Most notably, hospices at the 95th percentile discharged 50 percent or more of their patients alive.

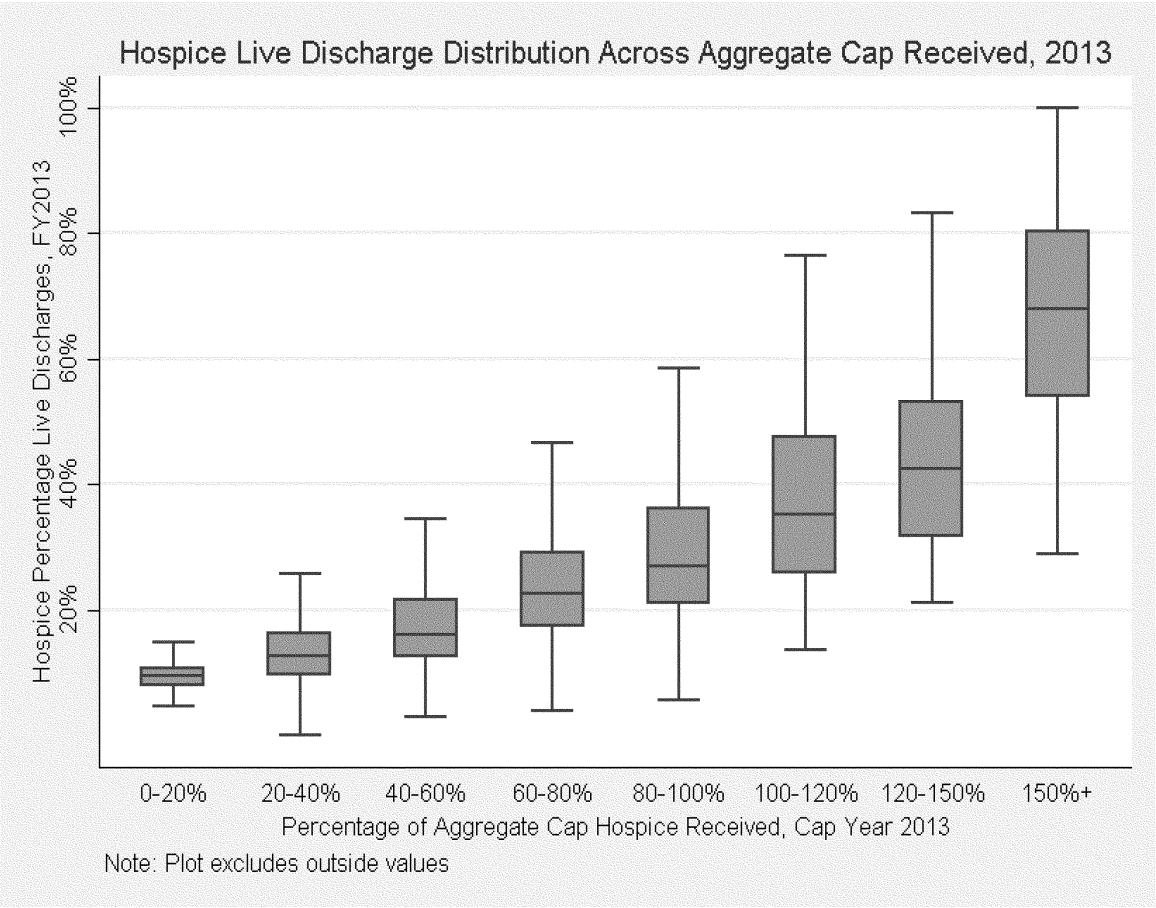
TABLE 11—DISTRIBUTION OF LIVE DISCHARGE RATES IN FY 2013 FOR HOSPICES WITH 50 OR MORE LIVE DISCHARGES

| Statistic | Live discharge rate % |
|---|---|
| 5th Percentile | 8.1 |
| 10th Percentile | 9.5 |
| 25th Percentile | 12.9 |
| Median | 18.3 |
| 75th Percentile | 26.6 |
| 90th Percentile | 39.1 |
| 95th Percentile | 50.0 |

**Note:** n = 3,096.

We analyzed hospices' aggregate cap status to determine whether there is a relationship between live discharge rates and their aggregate cap status. As described in section III.4.C and section III.D, when the Medicare Hospice Benefit was implemented, the Congress included an aggregate cap on hospice payments, which limits the total aggregate payments any individual hospice can receive in a year. Our FY 2013 analytic file contained 3,061 hospices with aggregate cap information and with more than 50 discharges in FY 2013. We found that 40.3 percent of hospices above the 90th percentile were also above the aggregate cap for the 2013 cap year. Conversely, only 3.8 percent of hospices below the 90th percentile were above the aggregate cap. As illustrated by the box plot below, the vertical axis represents the hospices' live discharge rates in FY 2013 and the horizontal axis represents the total payments hospices received at the end of the cap year of November 2012 through October 2013 relative to the total cap amount. Hospices under 100 percent on the X-axis are below the cap and those 100 percent or higher on the X-axis are above the cap. Our analysis found that hospices with higher live discharge rates are also above the cap. Specifically, the top of the rectangle represents the 75th percentile of live discharge rates, the middle line represents the median for that group, and the bottom of the rectangle is the 25th percentile of live discharge rates among all hospices ending the year within the range of cap percentages of live discharge rates as indicated by the horizontal axis (see Figure 2 below). We found that there appears to be a relationship with hospices with high live discharge rates and those that are above the aggregate cap.

FIGURE 2: DISTRIBUTION OF HOSPICE LIVE DISCHARGE RATES BY HOSPICE PAYMENT RECEIVED RELATIVE TO THE HOSPICE'S AGGREGATE CAP AMOUNT, FY 2013



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In FY 2013, we found that hospices with high live discharge rates also, on average, provide fewer visits per week. Those hospices with live discharge rates at or above the 90th percentile provide, on average, 3.97 visits per week. Hospices with live discharge rates below the 90th percentile provide, on average, 4.48 visits per week. We also found in FY 2013 that, when focusing on visits classified as skilled nursing or medical social services, hospices with live discharge rates at or above the 90th percentile provide, on average, 1.91 visits per week versus hospices with live discharge rates below the 90th percentile that provide, on average, 2.35 visits per week.

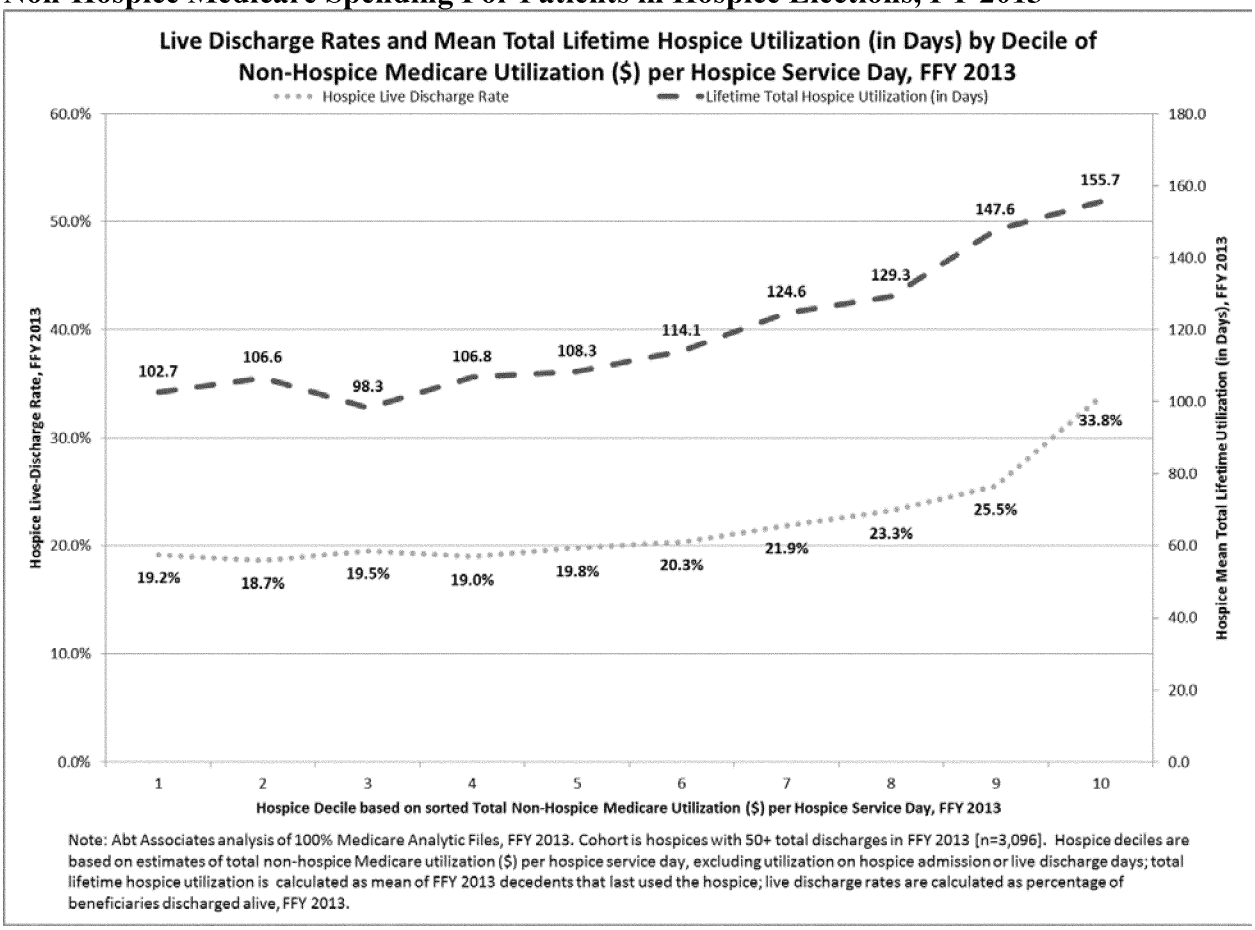
We examined whether there was a relationship between hospices with high live discharge rates, average length of stay, and non-hospice spending per beneficiary per day (see Table 12 and Figure 3 below). As described above in section III.A.2, we identified instances, in the aggregate and illustrated by case studies, where Medicare appeared to be paying for services twice because we would expect them to be covered by the hospice base payment rate, but were receiving items and services characterized as ''non-hospice'' under ''regular'' Medicare. Hospices with patients that, on average, accounted for $30 per day in non-hospice spending while in hospice (decile 10 in Table 12 and Figure 3 below) had live discharge rates that were, on average, about 33.8 percent and had an average lifetime length of stay of 156 days. In contrast, hospices with patients that, on average, accounted for $4 per day in non-hospice spending while in a hospice election (decile 1 in Table 12 and Figure 3 below) had live discharge rates that were, on average, about 19.2 percent and an average lifetime length of stay of 103 days. In other words, hospices in the highest decile, according to their level of non-hospice spending for patients in a hospice election, had live discharge rates and average lifetime lengths of stay that averaged 76 percent and 52 percent higher, respectively, than the hospices in lowest decile.

TABLE 12—MEAN DAILY NON-HOSPICE MEDICARE UTILIZATION AND SUM TOTAL NON-HOSPICE UTILIZATION BY HOSPICE PROVIDER DECILE BASED ON SORTED NON-HOSPICE MEDICARE UTILIZATION PER HOSPICE DAY, FFY 2013

| Decile | Non-hospice medicare ($) per hospice service day | Total non-hospice medicare ($) |
|---|---|---|
| 1 | $4.15 | $24,683,958 |
| 2 | 6.30 | 47,971,918 |
| 3 | 7.86 | 56,871,943 |
| 4 | 9.22 | 69,879,537 |
| 5 | 10.63 | 105,399,628 |
| 6 | 12.13 | 116,697,215 |
| 7 | 13.82 | 154,499,596 |
| 8 | 15.89 | 177,609,853 |
| 9 | 19.43 | 214,073,434 |
| 10 | 29.47 | 256,226,963 |
| All Hospices | 12.89 | 1,223,914,046 |

**Note:** Abt Associates analysis of 100% Medicare Analytic Files, FFY 2013. Cohort is hospices with 50+ total discharges in FFY 2013 [n = 3,096]. Hospice deciles are based on estimates of total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days.

**Figure 3: Average Hospice Live Discharge Rates and Lifetime Lengths of Stay by Decile of Non-Hospice Medicare Spending For Patients in Hospice Elections, FY 2013**




Note: Abt Associates analysis of 100% Medicare Analytic Files, FFY 2013. Cohort is hospices with 50+ total discharges in FFY 2013 [n=3,096]. Hospice deciles are based on estimates of total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days; total lifetime hospice utilization is calculated as mean of FFY 2013 decedents that last used the hospice; live discharge rates are calculated as percentage of beneficiaries discharged alive, FFY 2013.

The analytic findings presented above suggests that some hospices may consider the Medicare Hospice program as a long-term custodial benefit rather than an end of life benefit for beneficiaries with a medical prognosis of 6 months or less if the illness runs its normal course. As previously discussed in reports by MedPAC and the OIG, there is a concern that hospices may be admitting individuals who do not meet hospice eligibility criteria. We continue to communicate and collaborate across CMS to improve monitoring and oversight activities. We expect to analyze the additional claims and cost report data reported by hospices in the future to determine whether additional regulatory proposals to reform and strengthen the Medicare Hospice benefit are warranted.

We did not propose any new regulations or solicit any comments with this update on our hospice payment reform research and analyses. However, we received several comments.

A few commenters asserted that the fact that CMS did not release the technical report with the rule prevented them from being able to fully evaluate the impact of hospice payment reform. The 2015 Technical Report, that is planned for release later in 2015, describes some of the findings described above in this section of the rule. The 2015 Technical Report will not contain analyses described in section III.B related to hospice payment reform. All of the analysis in support of hospice payment reform can be found in section III.B of this final rule. In addition, a couple of commenters noted concerns about questionable provider behavior and asked what CMS plans to do in response to these findings. These providers felt that a targeted approach to address program integrity concerns may be more effective than a universal payment reform approach, which may harm those providers who are compliant with coverage requirements. Several commenters also noted concerns that a more timely and coordinated system is needed to address some of the payment vulnerabilities identified in our research. One industry commenter stated that there are many reasons that services are rendered outside of the Medicare hospice benefit and that often these reasons are result from a misunderstanding of the concept of ''relatedness''. This commenter discussed an industry-driven relatedness initiative that has been developed to help inform hospice decision making. Another commenter urged CMS to consider the reasons why hospices would counsel beneficiaries to revoke the hospice benefit to seek care outside of hospice. Several commenters stated that they have no control or knowledge over what services non-hospice providers are rendering or billing. They suggested that CMS provide outreach and education to hospitals, physicians, DME suppliers and other non-hospice providers on those services covered under the Medicare hospice benefit. Some commenters suggested a claims-based edit to prevent inappropriate payments. We appreciate these comments on the ongoing analysis presented and will continue to monitor hospice trends and vulnerabilities within the hospice

program to help inform future policy efforts and program integrity measures.

*B. Routine Home Care Rates and Service Intensity Add-On Payment*

1. Statutory Authority and Background

Section 3132(a) of the Affordable Care Act amended 1814(i) of the Act by adding paragraph (6)(D), that instructs the Secretary, no earlier than October 1, 2013, to implement revisions to the methodology for determining the payment rates for RHC and other services included in hospice care as the Secretary determines to be appropriate. The revisions may be based on an analysis of new data and information collected and such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care. In addition, we are required to consult with hospice programs and MedPAC on the revised hospice payment methodology.

This legislation emerged largely in response to MedPAC's March 2009 Report to Congress, which cited rapid growth of for-profit hospices and longer lengths of stay that raised concerns regarding a per diem payment structure that encouraged inappropriate utilization of the benefit.[32] MedPAC stated that a revised payment system would encourage hospice stays consistent with meeting the eligibility requirements of a medical prognosis of 6 months or less if the illness runs its normal course and increase greater provider accountability to monitor patients' conditions. In that same report, MedPAC stated that their goal was to ''strengthen the hospice payment system and not discourage enrollment in hospice, while deterring program abuse.''

As described in section III.A, CMS has transparently conducted payment reform activities and released research findings to the public since 2010. At that time, Abt Associates conducted a literature review and carried out original research to provide background on the current state of the Medicare hospice benefit. The initial contract also included several technical expert panel meetings with national hospice association representatives, academic researchers, and a cross-section of hospice programs that provided valuable insights and feedback on baseline empirical analyses provided by ASPE. A subsequent award to Abt Associates continues to support the dissemination of research analyses and findings, which are located in the ''Research and Analyses'' section of the Hospice Center Web page (*http://cms.hhs.gov/Center/Provider-Type/Hospice-Center.html*). In addition, research findings and payment reform concepts were set out in a 2013 technical report and a 2014 technical report, as well as in the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48234) and in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452). These research findings and concepts provide a basis for an important initial step toward payment reform outlined in section III.B.2 below.

Over the past several years, MedPAC, the Government Accountability Office (GAO), and OIG, have all recommended that CMS collect more comprehensive data to better evaluate trends in utilization of the Medicare hospice benefit. Furthermore, section 3132(a)(1)(C) of the Affordable Care Act specifies that the Secretary may collect additional data and information on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate. We have received many suggestions for ways to improve data collection to support larger payment reform efforts in the future. Based on those suggestions and industry feedback, we began collecting additional information on the hospice claim form as of April 1, 2014.[33] Additionally, 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.[34] Once available, we expect the data from hospice claims and cost reports to provide more comprehensive information on the costs associated with the services provided by hospices to Medicare beneficiaries by level of care.

a. U-Shaped Payment Model

For over a decade, MedPAC and other organizations have reported findings that suggest that the hospice benefit's fixed per-diem payment system is inconsistent with the true variance of service costs over the course of an episode. Specifically, MedPAC cited both academic and non-academic studies, as well as its own analyses (as summarized and articulated in MedPAC's 2002,[35] 2004,[36] 2006,[37] 2008[38] and 2009[39] Reports to Congress), demonstrating that the intensity of services over the duration of a hospice stay manifests in a 'U-Shaped' pattern (that is, the intensity of services provided is higher both at admission and near death and, conversely, is relatively lower during the middle period of the hospice episode). Since hospice care is most profitable during the long, low-cost middle portions of an episode, longer episodes have very profitable, long middle segments. This financial incentive appears to have resulted in hospices enrolling beneficiaries that are not truly eligible for the benefit (that is, do not have a life expectancy of 6 months or less) and ''may lead some patients, families, and providers to implicitly regard hospice as a source of basic health care for failing patients who did not qualify for skilled nursing facility or home health care and did not qualify for Medicaid or otherwise could not afford other sources of long-term custodial care,''[40] rather than the end-of-life care for which the benefit was originally designed.

In its March 2009 report, ''Reforming Medicare's Hospice Benefit,'' MedPAC recommended that the Congress require CMS to implement a payment system that would adjust per-diem hospice rates based on the day's timing within the hospice episode, with the express goal of mitigating the apparent inconsistency between payments and resource utilization (that is, costs) in hospice episodes.[41] Specifically, MedPAC recommended that payments near the beginning and ending of a stay be set at higher levels (weighted upwards) and payments during the

[32] Medicare Payment Advisory Commission (MedPAC). ''Reforming Medicare's Hospice Benefit.'' *Report to the Congress: Medicare Payment Policy*. March, 2009. Web. 18 Feb. 2015. *http://medpac.gov/documents/reports/Mar09_Ch06.pdf?sfvrsn=0.*

[33] CMS Transmittal 2864. ''Additional Data Reporting Requirements for Hospice Claims''. Available at: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf.*

[34] *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html?DLPage=1&DLSort=0&DLSortDir=ascending.*

[35] *http://www.medpac.gov/documents/contractor-reports/report-to-the-congress-medicare-beneficiaries'-access-to-hospice-(may-2002).pdf.*

[36] *http://www.medpac.gov/documents/reports/June04_ch6.pdf.*

[37] *http://www.medpac.gov/documents/reports/Jun06_Ch03.pdf.*

[38] *http://www.medpac.gov/documents/reports/Jun08_Ch08.pdf.*

[39] *http://www.medpac.gov/documents/reports/Mar09_Ch06.pdf.*

[40] *http://www.medpac.gov/documents/reports/Mar09_Ch06.pdf?sfvrsn=0.*

[41] Medicare Payment Advisory Commission (MedPAC). ''Reforming Medicare's Hospice Benefit.'' *Report to the Congress: Medicare Payment Policy*. March, 2009. Web. 18 Feb. 2015. *http://medpac.gov/documents/reports/Mar09_Ch06.pdf?sfvrsn=0.*

middle portion of care be set at lower levels (weighted downwards) to better mirror documented variation in cost over an episode's duration. Two primary weighting schemes were outlined in MedPAC's 2009 Report: A ''larger intensity adjustment'' (essentially a deeper U-shaped payment model, paying twice the base rate in the first 30/last 7 days and just a quarter of the daily rate in days 181+) and a ''smaller intensity adjustment'' (a relatively shallower U-shaped model, paying 1.5 times the base rate in the first 30/last 7 days and 0.375 times the daily rate in days 181+).

In its March 2015 Report to the Congress,[42] MedPAC reiterated its continued concerns regarding the ''mismatch between payments and hospice service intensity'' in the current hospice system and the ongoing need for payment reform. The Commission stated that ''Medicare's hospice payment system is not well aligned with the costs of providing care throughout a hospice episode. As a result, long hospice stays are generally more profitable than short stays.'' The Commission previously ''recommended that the hospice payment system be reformed to better match service intensity throughout a hospice episode of care (higher per diem payments at the beginning of the episode and at the end of the episode near the time of death and lower payments in the middle)''.

Other organizations have also explored the concept of a U-shaped payment model. ASPE, in conjunction with its contractor, Acumen LLC, analyzed hospice enrollment and utilization data. ASPE's research demonstrated that the resource use curve becomes more pronounced as episode lengths increase for hospice users, indicating that this effect occurs because resource use declines more substantially for the middle days relative to beginning and ending days in longer episodes of hospice care than it does for shorter episodes. The decline in the center of the 'U' is deeper for those users who receive RHC only during their hospice episode, which is the case for the majority of hospice patients. Recently, CMS' contracting partner, Abt Associates, conducted analysis of FY 2013 hospice claims data, showing that of the approximately 92 million hospice days billed, 97.45 percent are categorized as RHC.

b. Tiered Payment Model

As required under section 3132(a) of the Affordable Care Act, CMS also explored other options for hospice payment reform. Taking into consideration the research and analysis performed by MedPAC, ASPE, and others, our payment reform contractor, Abt Associates, examined hospice utilization data and modeled a hypothetical ''tiered'' payment system similar to MedPAC's U-shaped payment model by paying different per-diem rates for RHC according to the timing of the RHC day in the patient's episode of care. However, because analysis of hospice claims data found that a relatively high percentage of patients were not receiving skilled visits during the last days of life, the ''tiered payment model'' made the increased payments at end of life contingent on whether skilled services were provided. As reported in the FY 2015 Hospice Payment Rate Update final rule, in CY 2012, approximately 14 percent beneficiaries did not receive any skilled visits in the last 2 days of life (79 FR 50461). While this could be explained, in part, by sudden or unexpected death, the high percentage of beneficiaries with no skilled visits in the last 2 days of life causes concern as to whether beneficiaries and their families are not receiving needed hospice care and support at the very end of life. If hospices are actively engaging with the beneficiary and the family throughout the election, we would expect to see skilled visits during those last days of life. Therefore, in the tiered payment model, making the increased payment at the end of life contingent on whether skilled visits occurred in the last 2 days of life was thought of as one way to provide additional incentive for care to be provided when the patient needs it most.

The groupings in the tiered payment model, presented in Table13 below, were developed through Abt Associates' analyses of resource utilization over the hospice episode and clinical input. Using all RHC hospice service days from 2011, Abt then developed payment weights for each grouping by calculating its relative resource utilization rate compared to the overall estimate of resource use across all RHC days (see Table 13 below).

TABLE 13—AVERAGE DAILY RESOURCE USE BY PAYMENT GROUPS IN THE TIERED PAYMENT MODEL, CY 2011

| Group | Days of hospice | Implied weight |
|---|---|---|
| Group 1: RHC Days 1–5 | 2,800,144 | 2.3 |
| Group 2: RHC Days 6–10 | 2,493,004 | 1.11 |
| Group 3: RHC Days 11–30 | 7,767,918 | 0.97 |
| Group 4: RHC Days 31+ | 65,958,740 | 0.86 |
| Group 5: RHC During Last Seven Days, Skilled Visits During Last 2 Days | 2,832,620 | 2.44 |
| Group 6: RHC During Last Seven Days, No Skilled Visits During Last 2 Days | 476,809 | 0.91 |
| Group 7: RHC When Hospice Length of Stay is 5 Days or Less, Patient Discharged as ''Expired''. | 510,787 | 3.64 |
| Total | 82,840,022 | 1.0 |

The payment weighting scheme in this system, derived from observed resource utilization across the entire episode, would produce higher payments during times when service is more intensive (the beginning of a stay or the end of life) and produce lower payments during times when service is less intensive (such as the ''middle period'' of the stay). The tiered payment model was discussed in more detail in the FY 2014 Hospice Wage Index final rule (78 FR 48271) and in the Hospice Study Technical Report issued in April of 2013.[43]

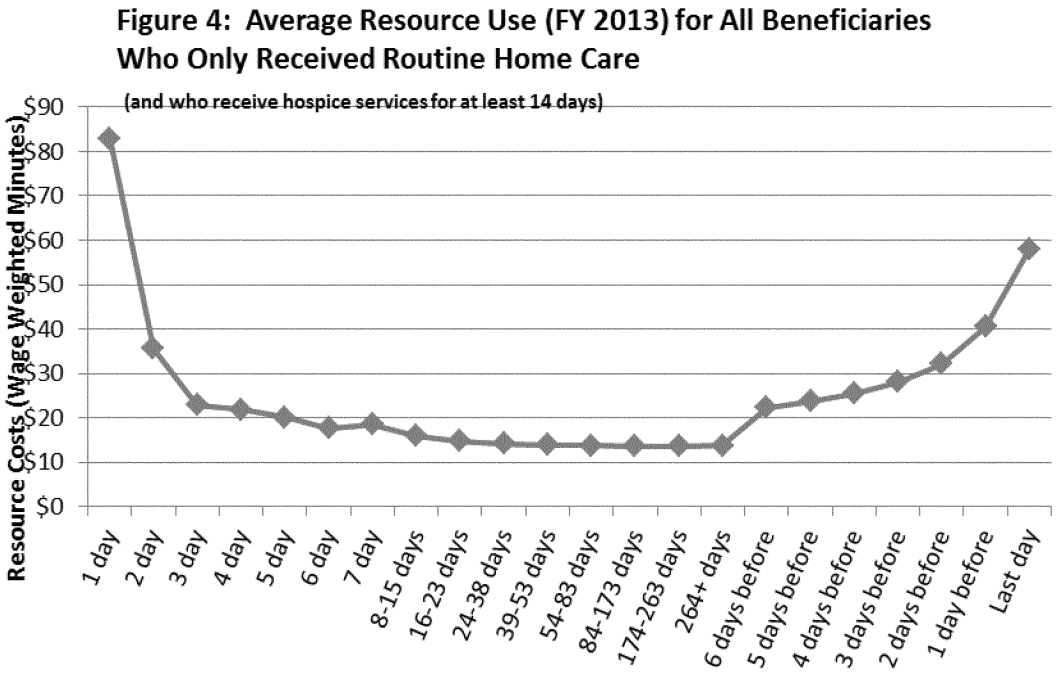
c. Visits During the Beginning and End of a Hospice Election

Updated analysis of FY 2013 hospice claims data continues to demonstrate a U-Shaped pattern of resource use. Increased utilization at both the beginning and end of a stay is demonstrated in Figure 4 below, where

[42] *http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf?sfvrsn=0.*

[43] *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Study-Technical-Report.pdf*

FY 2013 resource costs (as captured by wage-weighted minutes) are markedly higher in the first 2 days of a hospice election and once again in the 6 days preceding the date of death and on the date of death itself.




Analysis of skilled nursing and social work visits provided on the first day of a hospice election shows that nearly 89 percent of patients received a visit totaling 15 minutes or more, while 11 percent did not receive a skilled nursing visit or social work visit on the first day of a hospice election (see Table 14 below). The percentage of patients who did not receive a skilled nursing or social work visit on a given day increased to nearly 38 percent on the second day of a hospice election. In accordance with the hospice CoPs at § 418.54(a), hospices are required to have a RN complete an initial assessment of the hospice patient within 48 hours of election; therefore, we would expect to see a nursing visit occurring within the first 2 days of an election in order to be in compliance with the CoPs. We found that, in FY 2013, 96 percent of hospice patients did receive a skilled visit in the first 2 days of a hospice election. The percentage of patients that did not receive a skilled nursing or social work visit on any given day increased to about 65 percent by the sixth day of a hospice election. Overall, on any given day during the first 7 days of a hospice election, nearly 50 percent of the time the patient is not receiving a skilled visit (skilled nursing or social worker visit).

TABLE 14—FREQUENCY AND LENGTH OF SKILLED NURSING AND SOCIAL WORK VISITS (COMBINED) DURING THE FIRST SEVEN DAYS OF A HOSPICE ELECTION, FY 2013

| Visit length | First day (%) | Second day (%) | Third day (%) | Fourth day (%) | Fifth day (%) | Sixth day (%) | Seventh day (%) | First through seventh day (%) |
|---|---|---|---|---|---|---|---|---|
| No Visit | 11.0 | 37.7 | 56.0 | 59.1 | 62.0 | 65.6 | 64.2 | 49.3 |
| 15 mins to 1 hr | 12.8 | 27.1 | 22.2 | 20.6 | 20.4 | 20.1 | 22.3 | 20.7 |
| 1 hr 15 m to 2 hrs | 32.0 | 21.4 | 14.3 | 13.4 | 12.2 | 10.4 | 10.2 | 16.9 |
| 2 hrs 15 m to 3 hrs | 22.8 | 8.6 | 4.8 | 4.5 | 3.6 | 2.5 | 2.2 | 7.5 |
| 3 hrs 15 m to 3hrs45m | 8.5 | 2.6 | 1.3 | 1.2 | 0.9 | 0.6 | 0.5 | 2.4 |
| 4 or more hrs | 13.0 | 2.6 | 1.3 | 1.2 | 0.9 | 0.7 | 0.6 | 3.2 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**Source:** FY 2013 hospice claims data from the Standard Analytic Files for CY 2012 (as of June 30, 2013) and CY 2014 (as of December 31, 2013).

As we noted above, we are concerned that many beneficiaries are not receiving skilled visits during the last few days of life. At the end of life, patient needs typically surge and more intensive services are warranted. However, analysis of FY 2013 claims data shows that on any given day during the last 7 days of a hospice election, nearly 50 percent of the time the patient is not receiving a skilled visit (skilled nursing or social worker visit) (see table 15 below). Moreover, on the day of death nearly 30 percent of beneficiaries did not receive a skilled visit (skilled nursing or social work visit).

TABLE 15—FREQUENCY AND LENGTH OF SKILLED NURSING AND SOCIAL WORK VISITS (COMBINED) DURING THE LAST SEVEN DAYS OF A HOSPICE ELECTION, FY 2013

| Visit length (%) | Day of death (%) | One day before death (%) | Two days before death (%) | Three days before death (%) | Four days before death (%) | Five days before death (%) | Six days before death (%) | Last seven days combined (%) |
|---|---|---|---|---|---|---|---|---|
| No Visit | 27.8 | 38.7 | 45.2 | 49.8 | 53.2 | 55.8 | 58.0 | 46.3 |
| 15 mins to 1 hr | 23.9 | 27.9 | 26.5 | 25.1 | 24.2 | 23.5 | 22.8 | 24.9 |
| 1 hr 15 m to 2 hrs | 24.2 | 19.3 | 17.4 | 15.9 | 14.5 | 13.6 | 12.7 | 17.1 |
| 2 hrs 15 m to 3 hrs | 12.3 | 7.2 | 5.9 | 5.1 | 4.5 | 4.1 | 3.8 | 6.3 |
| 3 hrs 15 m to 3hrs45m | 4.4 | 2.4 | 1.9 | 1.6 | 1.4 | 1.2 | 1.1 | 2.1 |
| 4 or more hrs | 7.4 | 4.3 | 3.0 | 2.4 | 2.1 | 1.9 | 1.6 | 3.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

**Source:** FY 2013 hospice claims data from the Standard Analytic Files for CY 2012 (as of June 30, 2013) and CY 2014 (as of December 31, 2013).

We would expect that skilled visits are provided to the patient and family at end of life as the changing condition of the individual and the imminence of death often warrants frequent changes to care to alleviate and minimize symptoms and to provide support for the family. Although previous public comments stated that patients and families sometimes request no visits at the end of life, and there are rare instances where a patient passes away unexpectedly, we would expect that these instances would be rare and represent a small proportion of the noted days without visits at the end of life. However, the data presented in Table 15 above suggests that it is not rare for patients and families to have not received skilled visits (skilled nursing or social work visits) at the end of life. In the FY 2015 Hospice Wage Index and Payment Rate Update final rule, we noted that nearly 5 percent of hospices did not provide any skilled visits in the last 2 days of life to more than 50 percent of their decedents receiving routine home care on those last 2 days and 34 hospices did not make any skilled visits in the last 2 days of life to any of their decedents who died while receiving routine home care (79 FR 50462).

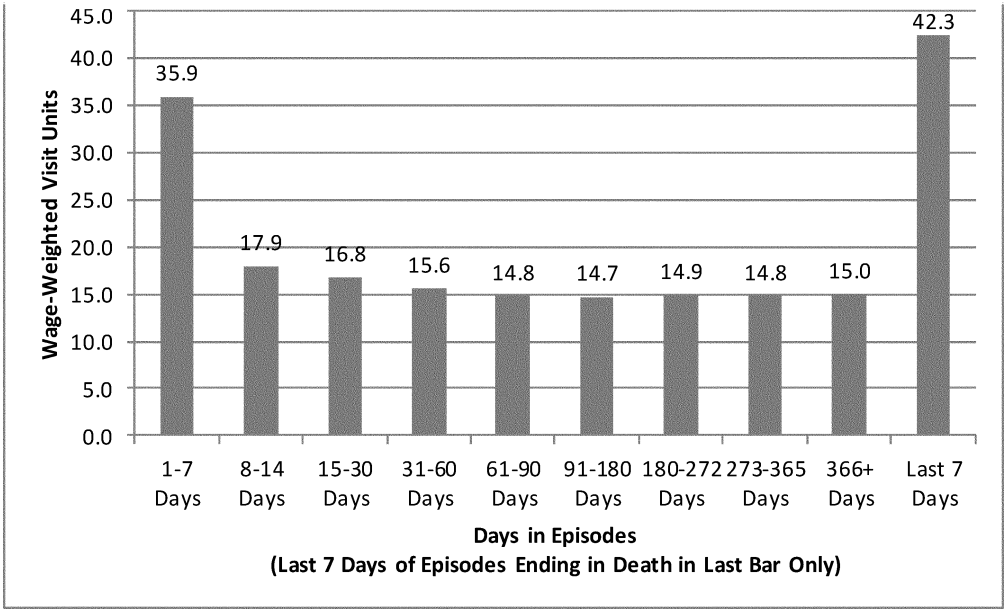
2. Routine Home Care Rates

RHC is the basic level of care under the Hospice benefit, where a beneficiary receives hospice care, but remains at home. With this level of care, hospice providers are currently reimbursed per day regardless of the volume or intensity of services provided to a beneficiary on any given day. As stated in the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48234), ''it is CMS' intent to ensure that reimbursement rates under the Hospice benefit align as closely as possible with the average costs hospices incur when efficiently providing covered services to beneficiaries.'' However, as discussed in section III.B.1 above, there is evidence of a misalignment between the current RHC per diem payment rate and the cost of providing RHC. In order to help ensure that hospices are paid adequately for providing care to patients regardless of their palliative care needs during the stay, while at the same time encouraging hospices to more carefully determine patient eligibility relative to the statutory requirement that the patient's life expectancy be 6 months or less, in the FY 2016 Hospice Wage Index and Payment Rate Update proposed rule (80 FR 25831), we proposed to use the authority under section 1814(i)(6)(D) of the Act, as amended by section 3132(a) of the Affordable Care Act to revise the current RHC per diem payment rate to more accurately align the per diem payments with visit intensity (that is, the cost of providing care for the clinical service (labor) components of the RHC rate). We proposed to implement, in conjunction with a SIA payment discussed in section III.B.3 below, two different RHC rates that would result in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for days 61 and beyond of hospice care.

The proposed two rates for RHC were based on an extensive body of research concerning visit intensity during a hospice episode as cited throughout this section. We consider a hospice ''episode'' of care to be a hospice election period or series of election periods. Visit intensity is commonly measured in terms of wage-weighted minutes and reflects variation in the provision of care for the clinical service (labor) components of the RHC rate. The labor components of the RHC rate comprise nearly 70 percent of the RHC rate (78 FR 48272). Therefore, visit intensity is a close proxy for the reasonable cost of providing hospice care absent data on the non-labor components of the RHC rate, such as drugs and DME. As shown in Figures 5 and 6 below, the daily cost of care, as measured wage-weighted minutes, declines quickly for individual patients during their hospice episodes, and for long episode patients, remains low for a significant portion of the episode. Thus, long episode patients are potentially more profitable than shorter episode patients under the current per diem payments system in which the payment rate is the same for the entire episode. At the same time, the percent of beneficiaries that enter hospice less than 7 days prior to death has remained relatively constant (approximately 30 percent) over this time period, meaning the increase in the average episode length can be attributed to an increasing number of long stay patients. We found that the percent of episodes that are more than 6 months in length has nearly doubled from about 7 percent in 1999 to 13 percent in 2013.

Figure 5 displays the pattern of wage-weighted minutes by time period within beneficiary episodes, but separating out the last 7 days of the episode for decedents. The wage-weighted minutes for the last 7 days are displayed separately by the bar furthest to the right of the Figure 5. The visit intensity curve declines rapidly after 7 days and then at a slower rate until 60 days when the curve becomes flat throughout the remainder of episodes (excluding the last 7 days prior to death). It is for this reason that we proposed to pay a higher rate for the first 60 days and a lower rate thereafter. It is clear from the figure that visit utilization is constant from day 61 on, until the last 7 days for decedents. We believe the most important reason for implementing a different RHC rate for the first 60 days versus days 61 and beyond is that we must account for differences in average visit intensity between episodes that will end within 60 days and those that will go on for longer episodes.

**Figure 5: Wage-Weighted Minutes per RHC Day, CY 2013**




As Figure 6 demonstrates, beneficiaries whose entire episode is between 8 and 60 days do have higher wage-weighted minute usage than those with longer stays. Using 60 days for the high RHC rate as opposed to an earlier time assures that hospices have sufficient resources for providing high quality care to patients (for example, 1 through 60 days) whose average daily visit intensity is higher than for longer stay patients.

**Figure 6: RHC Wage-Weighted Minutes Per Day, Minus Last 7 Days, All Episodes Ending in CY 2013**

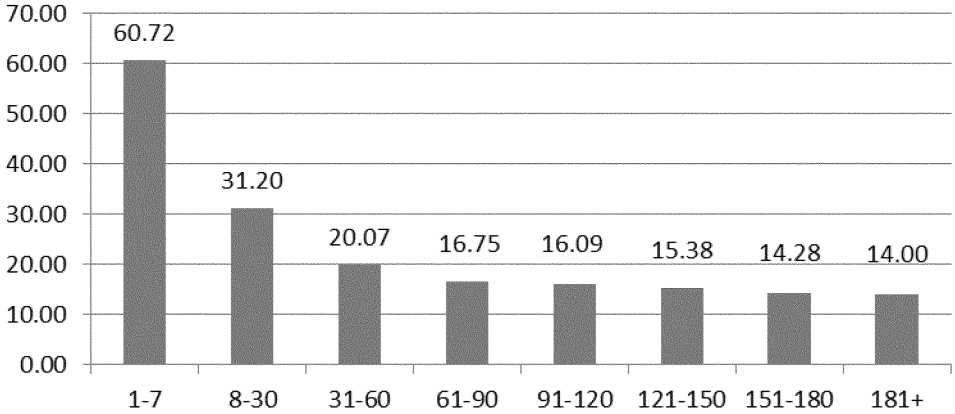



Table 16 below describes the average wage-weighted minutes for RHC days in FY 2014, calculated both in specific phases within an episode as well as overall.

TABLE 16—AVERAGE WAGE WEIGHTED MINUTES PER RHC DAY, FY 2014

| Phase of days in episode | Average wage-weighted minutes | RHC days | Ratio of wage weighted minutes for each row divided by wage weighted minutes for days 1–7 |
|---|---|---|---|
| 1–7 Days | $39.29 | 5,446,868 | 1.0000 |
| 8–14 Days | 20.12 | 4,310,630 | 0.5121 |
| 15–30 Days | 17.96 | 7,752,375 | 0.4570 |
| 31–60 Days | 16.09 | 10,758,904 | 0.4097 |
| 61–90 Days | 15.44 | 8,123,686 | 0.3930 |
| 91–180 Days | 14.93 | 16,271,786 | 0.3799 |
| 181–272 Days | 14.78 | 10,118,998 | 0.3762 |
| 273–365 Days | 14.90 | 6,876,814 | 0.3793 |
| 365 up Days | 15.05 | 16,029,597 | 0.3830 |
| Total RHC Days | 17.21 | 85,689,658 | 0.4380 |

In Table 16, the average wage-weighted minutes per day for days 1 through 7 describe the baseline for the other phases of care, set at a value of one. Given the demands of the initial care in an episode, resource intensity is highest during this first week of an episode, and resource needs decline steadily over the course of an episode. The overall average wage-weighted minutes per day across all RHC days equals $17.21 as described in the last row in table 16 above. We then calculated the average wage-weighted minute costs for the two groups of days (Days 1 through 60 and Days 61+) utilizing FY 2014 RHC days multiplied by the 2013 Bureau of Labor Statistics (BLS) average hourly wage values for the relevant disciplines, as follows: Skilled Nursing: $40.07; Physical Therapy: $55.93; Occupational Therapy: $55.57; Speech Language Pathology: $60.21; Medical Social Services: $38.25; and Aide: $14.28. The average wage-weighted minute cost for days 1 through 60 equals to $21.69 while the average wage weighted minutes for days 61 or more equals $15.01.

To calculate the RHC payment rate for days 1 through 60, we compared the average wage-weighted minutes per day for days 1 through 60 to the overall average wage-weighted minutes per day multiplied by the labor portion of the FY 2015 RHC rate (column 4 in Table 17 below), which equals ($21.69/$17.21)*$109.48 = $137.98. Similarly, the RHC payment rate for days 61+ equals the average wage-weighted minutes per day for days 61+ divided by the overall average wage-weighted minutes per day multiplied by the labor portion of the FY 2015 RHC rate (column 4 in Table 17 below), which equals ($15.01/$17.21)*$109.48 = $95.49.

TABLE 17—FY 2015 RHC RATE REVISED LABOR PORTION CALCULATION

| (1) | (2) | (3) | (4) | (5) | (6) |
|---|---|---|---|---|---|
| | FY 2015 RHC Payment rate | RHC Labor-related share | FY 2015 RHC Payment rate—labor portion | Average wage weighted minutes for RHC differential rate/overall RHC average wage weighted minutes | Revised FY 2015 labor portion |
| Days 1–60 | $159.34 | × 0.6871 | $109.48 | × 1.2603 ($21.69/$17.21) | $137.98 |
| Days 61+ | 159.34 | × 0.6871 | 109.48 | × 0.8722 ($15.01/$17.21) | 95.49 |

As discussed in section III.C of this rule, currently, the labor-related share of the hospice payment rate for RHC is 68.71 percent. The non-labor share is equal to 100 percent minus the labor-related share, or 31.29 percent. Given the current base rate for RHC for FY 2015 of $159.34, the labor and non-labor components are as follows: For the labor-share portion, $159.34 multiplied by 68.71 percent equals $109.48; for the non-labor share portion, $159.34 multiplied by 31.29 percent equals $49.86. After determining the labor portion for the RHC rate for the first 60 days and the labor portion for the RHC rate for days 61 and over, we add the non-labor portion ($49.86) to the revised labor portions. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the RHC rates will be adjusted by a ratio of the estimated total labor payments for RHC using the current single rate for RHC to the estimated total labor payments for RHC using the two rates for RHC and taking into account area wage adjustment. This ratio results in a budget neutrality adjustment of 0.9978, which is due to differences in the average wage index for days 1–60 compared to days 61 and beyond, as shown in column 3 in Table 18 below. Finally, adding the revised labor portion with budget neutrality to the non-labor portion results in revised FY 2015 RHC payment rates of $187.54 for days 1 through 60 and $145.14 for days 61 and beyond.

TABLE 18—RHC BUDGET NEUTRALITY ADJUSTMENT FOR RHC RATES

| (1) | (2) | (3) | (4) | (5) | (6) |
|---|---|---|---|---|---|
| | Revised FY 2015 Labor portion | Budget neutrality factor [1] | Revised FY 2015 labor portion with budget neutrality | FY 2015 Non-labor portion | FY 2015 Revised RHC payment rates |
| Days 1–60 | $137.98 | × 0.9978 | $137.68 | $49.86 | $187.54 |
| Days 61+ | 95.49 | × 0.9978 | 95.28 | 49.86 | 145.14 |

[1] The budget neutrality adjustment is required due to differences in the average wage index for days 1–60 compared to days 61 and beyond.

The RHC rates for days 1 through 60 and days 61 and over (column 6 of Table 18 above) would replace the current single RHC per diem payment rate with two new RHC per diem rates for patients who require RHC level of care during a hospice election. In order to mitigate potential high rates of discharge and readmissions, we proposed that the count of days follow the patient. For hospice patients who are discharged and readmitted to hospice within 60 days of that discharge, his or her prior hospice days would continue to follow the patient and count toward his or her patient days for the receiving hospice upon hospice election. The hospice days would continue to follow the patient solely to determine whether the receiving hospice would receive payment at the day 1 through 60 or day 61 and beyond RHC rate. Therefore, we consider an ''episode'' of care to be a hospice election period or series of election periods separated by no more than a 60 day gap.

Summaries of the public comments and our responses to comments on all aspects of the RHC payment rates are summarized below:

*Comment:* Nearly all commenters were supportive of our proposal to create two RHC rates, one higher rate for the first 60 days of hospice care and a second lower rate for days 61 and beyond. MedPAC supported both the proposed new structure for RHC payments and the proposed Service Intensity Adjustment (SIA) in section III.B.3 below, and stated that these two proposals begin to better align payments with the u-shaped pattern of hospice visits throughout an episode. Several commenters went on to add that the proposed RHC rates would increase reimbursement and accurately align the higher cost of care for relatively short stay patients while fairly reimbursing the lower cost of care for long stay patients.

*Response:* We thank the commenters for their support. We agree that our proposal to create two RHC rates, one for days 1–60 and another for days 61 and beyond, addresses observed differences in resource intensity between the first 60 days of hospice care and hospice care that extends beyond 60 days.

*Comment:* Several commenters questioned why CMS differentiated between a higher and a lower RHC rate at 60 days. Several commenters stated that the costs do not decrease after 60 days and that costs often increase near the end of life. While the proposed SIA, discussed in section III.B.3 below, helps to compensate for increased costs at end of life, the proposed RHC rates do not take into consideration the increased costs of medications, sometimes extra equipment, nor the real costs of providing care. One commenter stated that once a patient exceeds 60 days of care, the lower RHC rate simply re-introduces the current incentive to provide long spells of potentially unnecessary care. The commenter went on to add that the proposed RHC rates are, in reality, two flat per diem rates that perpetuate the shortcomings of the current payment approach.

A few commenters recommended that CMS maintain consistency with already established benefit periods and should, instead of differentiating payment at 60 days, differentiate RHC payments between days 1–90 and days 91 and beyond, or even apply the higher rate for the first 6 months and then the lower rate thereafter to maintain consistency with the eligibility requirement of a ''life expectancy of 6 months or less if the illness runs its normal course''. One commenter agreed with CMS' proposal to create two RHC rates, but recommended that in the future, CMS consider establishing a separate rate for the first 7 or 14 days of care and a lower rate thereafter.

Several commenters stated that while they support the proposal to create two RHC rates, further refinements may be necessary in the future. Specifically, one commenter stated that CMS may need to further weight the first 60 days or transition from the first to the second RHC rate earlier than day 61. Several commenters added that CMS may find that hospice payments should be adjusted based on beneficiary characteristics, such as comorbidities and socio-economic status and that CMS should develop a reimbursement methodology that reflects the actual cost of caring for individuals with different diagnoses related to the terminal illness as well as individuals that receive higher cost treatments (for example, chemotherapy, total parenteral nutrition).

*Response:* As discussed above, visit intensity declines after 7 days of hospice care until day 60 of hospice care when the visit intensity becomes flat throughout the remainder of the hospice episode (excluding the last 7 days prior to death). It is for this reason that we proposed to pay a higher rate for the first 60 days and a lower rate thereafter. CMS did consider establishing an even higher rate for the first 7 days of care; however, given concerns voiced by the National Hospice and Palliative Care Organization (NHPCO), MedPAC, and others that short lengths of stay may prevent patients and family caregivers from benefiting fully from the range of specialized services and compassionate care that hospices offer, we decided to propose a higher RHC rate for days 1–60 and an lower RHC rate for days 61 and beyond as to not provide a larger incentive for hospices to target short stay patients. In addition to the higher RHC rate for days 1–60, the proposed SIA, discussed in section III.B.3 below, would increase the reimbursement further for short stay patients, including those with lengths of stay of 7 days or less, as long as skilled visits by a registered nurse or social worker are provided to the patient at end of life. For those commenters that suggested CMS pay a higher rate for the first 90 days and then a lower rate thereafter, we concur with MedPAC's comments on the proposed rule cautioning against any changes to the proposed structure that would lengthen the period for the initial payment rate (for example, days 1–90) because that would result in a lower initial payment rate and represent

a smaller increase in reimbursement for shorter stays.

CMS recently revised the freestanding hospice cost report form for cost reporting periods beginning on or after October 1, 2014. On April 1, 2014, we began requiring hospices to report on the hospice claim, in line item detail, the charges associated with infusion pumps and non-injectable and injectable prescription drugs (as dispensed). In section III.F of this final rule, we are clarifying that, effective October 1, 2015, hospices are to report all patient diagnoses (related and unrelated) on the hospice claim form. Once several years of additional data are available for analysis, we will determine whether additional changes to the hospice payment system are needed in the future, including analysis to determine whether a case-mix system for hospice payments would be an appropriate, viable option.

*Comment:* Several commenters stated that the proposed RHC rates would allow some hospices to ''game the system'' by receiving the full benefit of the initial 60 day period then discharging the patient, leaving other smaller, non-profit hospices to assume care for someone with decreased reimbursement. Commenters expressed concern that this payment differential could provide an incentive for hospices to target and admit larger numbers of short stay patients, and to discharge or decline to admit, patients who hospice care would be paid at the lower rate causing more patients to show up at the emergency room multiple times for pain management and symptom control. One commenter stated that the proposed RHC rates could cause hospices to shift away from caring for patients with non-cancer diagnoses with unpredictable lengths of stay. Commenters further urged CMS to monitor for discharges around day 60 and to put mechanisms in place to prevent hospices from discharging a patient around day 60. Some commenters suggested that CMS address the areas of illegal and unethical behaviors of those individual hospices who do not comply with the rules and regulations of the Medicare hospice benefit and that CMS not apply a universal payment reform that impacts those hospice providers who are in compliance with the rules and regulations.

*Response:* Reiterating what we stated in the FY 2016 Hospice Wage Index and Payment Rate Update proposed rule (80 FR 25831), we will monitor the impact of this proposal, including trends in discharges and revocations, and propose future refinements if necessary. We want to remind hospices that, pursuant to section 418.26, there are only three reasons why a hospice may discharge a patient—(1) If the hospice patient moves outside of the hospice's service area or transfers to another hospice; (2) if the hospice determines the patient is no longer terminally ill; or (3) for cause when the patient or others living in the patient's home are disruptive, abusive, or uncooperative. Program integrity and oversight efforts are being considered to address fraud and abuse and such efforts include, but are not limited to, medical review, MAC audits, Zone Program Integrity Contractor actions, RAC activities, or suspension of provider billing privileges.

*Comment:* Commenters stated that the proposed RHC rates do not address the challenges faced by hospices with very short stay patients. A few commenters stated that instead of adding complexity to the billing process, CMS should target its efforts on ensuring beneficiaries are informed early and often on the value of services they are entitled to under the Medicare hospice benefit and target providers experiencing high profit margins and separately evaluate the level and intensity of such providers and those providers' case-mix and staffing strategies.

*Response:* While the proposed RHC rates themselves do not specifically address very short stay patients, the proposed SIA, discussed in section III.B.3 below, would apply to the last 7 days of life. We believe that the higher RHC rate in conjunction with the proposed SIA payment will mitigate some of the financial concerns associated with these very short stay patients. CMS makes every effort to provide outreach and education to Medicare beneficiaries and providers regarding all Medicare benefits, including those services available under the Medicare hospice benefit. Information regarding benefit coverage is available via MLN articles, the annual Medicare & You handbook, and on the Medicare.gov Web site, to name a few. We will continue to monitor provider behavior and will continue efforts to protect beneficiary access to high quality, coordinated and comprehensive hospice care under the Medicare hospice benefit.

*Comment:* Most commenters, including MedPAC, generally agreed that for hospice patients who are discharged and readmitted to hospice within 60 days of that discharge, his or her prior hospice days should continue to follow the patient and count toward his or her patient days for the receiving hospice upon hospice election. MedPAC stated that this policy is necessary to minimize financial incentives for hospice patients to be dis-enrolled and re-enrolled, or transferred between hospice providers, for the purposes of obtaining a higher payment rate. MedPAC went on to state that they would also support a longer ''break'' than 60 days, but does not believe this threshold should be shorter. A few commenters did not agree with having the hospice days follow the patient and added that concerns exist about instances where the patient transfers to another hospice and the inequities for the second hospice if they are not entitled to the higher RHC rate after 60 days have lapsed. A few commenters suggested that CMS allow the second hospice to receive the higher RHC rate or an add-on payment just for the first seven days of a new election after being discharged from a different hospice provider. One commenter suggested that for live discharges prior to 60 days, the lower tiered RHC rate be applied to all claims where a patient is in their initial 60 days. Other commenters suggested that CMS monitor this issue and whether it has any effect on access to hospice care. One commenter suggested that CMS' proposed ''episode'' definition (a hospice election period or series of election periods separated by no more than a 60 day gap) may be most appropriate to apply to those hospices that share common ownership rather than to all hospice providers.

*Response:* We thank the commenters for their support. We want to reiterate that in order to mitigate potential high rates of discharge and readmissions (''churning''), we proposed that the count of days follow the patient. We continue to believe that this policy is both necessary and appropriate. Allowing for a higher payment for the first seven days of a new hospice election without a gap in hospice care of greater than 60 days goes against our intent to mitigate the incentive to discharge and readmit patients at or around day 60 for the purposes of obtaining a higher payment. As we stated above, we will monitor the impact of the new RHC rates policy based on claims data, including trends in discharges and revocations, and implement future refinements to the rates or policy changes, if necessary. In response to the commenter that suggested that for live discharges prior to 60 days, the lower tiered RHC rate be applied to all claims where a patient is in their initial 60 days, we will take this suggestion under advisement for future rulemaking after analyzing any trends in discharges and revocations as a result of the policy changes finalized in this rule. Finally, the Medicare claims processing

system is not able to identify hospices that share common ownership. In the future, if this capability is developed in the future, we will consider whether it would be appropriate to restrict the application of episode definition to hospices that share common ownership.

*Comment:* Some commenters expressed concern about the ability of CMS, the state Medicaid agencies, and hospices to make the necessary systems changes and undertake education and training to be ready to implement the new billing system by October 1, 2015. Commenters urged CMS to be mindful to the challenges associated with any new hospice payment system that affects Medicaid. A few commenters suggested that CMS should pilot test this new methodology before implementation in order to determine any unintended consequences as well as better determine the administrative burden imposed. Other commenters suggested that CMS consider a one-year demonstration project to test the new RHC payment rates for all hospices under the jurisdiction of one MAC. A few commenters stated that the two RHC rates should be phased in, similar to how CMS implemented the new Ambulatory Surgical Center (ASC) payment system and the phase-out of the hospice BNAF. One commenter suggested that CMS delay implementation of this final rule until after ICD–10–CM implementation.

*Response:* Although some commenters suggested that, before national implementation, CMS should conduct a demonstration project or pilot test the two proposed RHC rates, we do not believe that a demonstration project or pilot test is warranted. CMS has been working with our contractors to develop systems changes to the fullest extent possible in parallel with the development of this rule. Our system maintainers will have their full software development lifecycle to implement these changes. We do not have concerns about the readiness of Medicare systems on October 1, 2015. Regarding hospice system changes, we do not anticipate that this rule will require any changes to hospice billing instructions so systems for submitting claims and receiving Medicare payment should not be affected and the need for retraining billing staff should be limited, but hospices may need to change their internal accounting systems . Further, the data presented in the proposed rule sufficiently demonstrate that CMS needs to implement the proposed RHC payment rate change to better align hospice payments with resource use. Any phase-in of the proposed RHC rates would not be appropriate given the current misalignment between payments and resource use and the ability of CMS to effectively implement the required systems changes. Likewise, CMS does not believe that a delay in the implementation of the two RHC rates would be warranted due to the implementation of ICD–10–CM.

While CMS is ready and able to make the required systems changes to implement a change from a single RHC per diem payment rate to two RHC per diem payment rates, we anticipate that state Medicaid agencies may encounter difficulties in making the necessary systems and software changes to be ready to implement the proposed RHC rates on October 1, 2015. Therefore, we will delay implementation of both the proposed RHC rates and the SIA payment until January 1, 2016 in order to ensure, to the greatest extent possible, that the state Medicaid agencies can likewise implement these changes. Between October 1, 2015 and December 31, 2015, hospices will continue to be paid a single FY 2016 RHC per diem payment amount. Effective January 1, 2016, the RHC rates for days 1 through 60 and days 61 and beyond would replace the single RHC per diem payment rate (the RHC per diem rates are listed in section III.C of this final rule). We assure hospices that CMS and the MACs will take steps to educate and train hospice providers and state Medicaid agencies on the policy changes and associated systems changes finalized in this rule so that hospices and the state Medicaid agencies are ready to implement the two RHC rates on January 1, 2016.

*Comment:* Several commenters stated that the proposed rule did not describe how hospice days will be counted for beneficiaries in existing hospice episodes that continue through October 1, 2015. Several commenters, including MedPAC, stated that the patient's day count on October 1, 2015 should be based on the total number of days in the hospice episode, even those days prior to October 1, 2015 (taking into account the proposed policy that the episode days follow the patient and 60 days without hospice care would trigger a new hospice episode). A few commenters stated that the new RHC rates should apply just for new admissions starting on or after October 1, 2015 and a few other commenters added that existing admissions should continue to be paid the existing single RHC rate for a year after implementation. A few commenters asked whether the 60 day hospice episode period is counting 60 days of continuous days of hospice care regardless of level of care or whether it is only counting days at the RHC level of care and whether days of care that were provided, but not billable, would be included in the count.

*Response:* Table 16, used to establish the proposed RHC payment rates for days 1–60 and days 61 and beyond, takes into account the patient's episode day count based on the total number of days included in that episode regardless of level of care, whether those days were billable or not, and taking into account any instances where the patient was not receiving hospice care for more than 60 days, which would trigger a new hospice episode for the purpose of determining whether to pay the higher versus the lower RHC rate. We agree with MedPAC that it would not be appropriate to reset all hospice patients' episodes to day 1 on January 1, 2016 since patients who have already been in hospice for at least 60 days would not require the higher base payment rate associated with the first 60 days of the hospice episode. Likewise, we agree with MedPAC that allowing patients in existing elections to remain under the prior single RHC rate system would perpetuate concerns about payments being misaligned with costs for the longest-stay patients. Therefore, we believe that the most appropriate approach is to calculate the patient's episode day count based on the total number of days the patient has been receiving hospice care, separated by no more than a 60 day gap in hospice care, regardless of level of care or whether those days were billable or not. This calculation would include hospice days that occurred prior to January 1, 2016.

*Comment:* Some commenters stated that it was unclear from the proposal whether hospices will simply bill a RHC day and CMS will determine the count of days for the patient and pay the appropriate rate, or whether hospices will be responsible for determining the patient day count and billing at the correct rate. A few commenters questioned how CMS would address instances where a hospice is delayed in filing a Notice of Termination/Revocation and the days that the beneficiary was served by a previous hospice program may not be ''visible'' for purposes of determining the day count and the appropriate billing rate. One commenter suggested that CMS should be responsible for the count of days, rather than individual hospices. One commenter recommended that CMS not finalize its proposal to have the count of days follow the patient as this could become problematic from a billing perspective for receiving hospices in instances where a previous hospice provider does not bill their

hospice claims for its patients in a timely manner. Another commenter recommended that CMS eliminate the sequential billing requirement so that there would be fewer implementation problems associated with the proposed reimbursement changes. Finally, one commenter questioned if payments are made to the hospice and are later found to have been the wrong rate because of missing or inaccurate information on the day count, what the process would be for reconciliation and recoupment and over what time period might this occur.

*Response:* Hospices will not be required to change how they bill for RHC days to comply with the proposed higher RHC rate for the first 60 days of care and a lower rate thereafter. CMS' claims processing system will be responsible for the count of days, rather than the individual hospices, and will pay the appropriate rate accordingly. We believe this should alleviate hospice providers' concerns about having access to timely information on the patients' day count. There may be cases where a hospice submits a claim for a new admission and expects payment days under the high RHC rate because they are unaware of a prior admission in a sequence of elections. If the prior hospice's benefit period is posted in the Common Working File (CWF) at the time the second hospice's claim is processed, Medicare systems will pay the low RHC rate on that claim and no recoupment will result. If the two hospices' benefit periods are processed out of sequence, this typically requires that the second hospice's claims be cancelled and reprocessed. When Medicare systems reprocess the claims, they will pay the low RHC rate and any difference between the two rates will be recouped on the provider's next remittance advice. While we are not eliminating the sequential billing requirement at this time, we will consider whether the elimination of that requirement may be appropriate in the future.

*Comment:* Several commenters asked how hospices will be able to determine and confirm the days on service for a new hospice admission. One commenter recommended that a separate count be established to track and report the 60 day ''break'' in service so it is clear to hospice providers if a patient is within the first 60 days of a hospice episode. One commenter provided the following scenario:

- Patient begins hospice care on day one
- Patient discharged on day five
- Patient does not receive hospice care for 50 days
- Patient is then re-admitted.

The commenter asked whether the day count would leave 55 more days to be paid the higher RHC rate, or only 5 days to be paid at the higher RHC rate. One commenter questioned how the count of days would work for transfers where both hospices may bill on the day of transition.

*Response:* If a patient is discharged and readmitted within 60 days of that discharge, then the day count would start back where they were at discharge. In the scenario described above, the day count would leave 55 more days to be paid the higher RHC rate. When a patient transfers hospices and there is no gap in care, the transfer day (both hospices will be including the same date on their claim) will only be counted as 1 day. Hospices can access this information through the HIPAA Eligibility Transaction System (HETS), which is intended to allow the release of eligibility data to Medicare Providers, Suppliers, or their authorized billing agents for the purpose of preparing an accurate Medicare claim, determining Beneficiary liability or determining eligibility for specific services. The hospice data provided by the Common Working File (CWF) and the HETS system includes the actual start and end date of the hospice benefit days. That information will help hospices determine how many days the hospice benefit was utilized. The HETS system allowable date span is up to 12 months in the past, based on the date the transaction was received. The data return in the HETS system is driven by the date requested in the hospice's eligibility request. To ensure that all hospice episodes available in the HETS system are returned, hospices should request a date 12 months prior from the date of the request. If a hospice does not have access to the CWF or the HETS system, the hospice can access this data via their MAC's Portal, the MAC's Interactive Voice Response (IVR) unit, or request a direct access to the HETS system. A hospice that uses a clearinghouse may already have access to the HETS system.

*Comment:* A few commenters had extensive comments on the technical aspects in implementing the proposed RHC rates and the SIA payments. For example, some commenters questioned: (1) Whether the claims processing system can accommodate a break in line item detail when the revenue code does not change, but the rate does; (2) how the electronic remittance advice will reflect multiple payment rates for revenue code 0651; (3) will the two RHC rates affect revenue reporting on the hospice cost report, and if so, will the PS&R report summarize the needed data appropriately; and (4) how will Medicare secondary payer processing apply the two RHC rates on claims billed to a primary payer that utilizes a single rate.

*Response:* We do not anticipate that this rule will require any changes to the hospice cost report form to differentiate between the two RHC rates and thus we do not anticipate that this rule will require CMS modify the PS&R report. There will often be cases where the RHC rate changes during a period RHC that is shown on a single line item on a claim (for example, an RHC line shows 20 days of care and the high RHC rate ends after day 10). The line item should not be split in this case. Medicare billing instructions for hospice are not changing due to this rule. Existing instructions require that level of care revenue code lines should only be repeated if the site of service changes. A claim submitted with consecutive RHC lines reporting the same site of service HCPCS code will be returned to the provider. Medicare systems will combine the high and low RHC rates for the applicable days in the total payment for the RHC line item. No changes to the electronic remittance advice are planned as a result of this rule. If remittance advice coding to identify lines that are paid using the high RHC rate or that are paid at multiple rates would be beneficial, CMS will consider requesting and implementing such coding in future program instructions. Regarding Medicare Secondary Payer (MSP), a primary payer's method of payment frequently differs from Medicare's method. This policy does not change the calculation of MSP amounts. The primary payer's total payment for the claim, the claim charges and the Medicare primary payment amount are subject to the MSP calculations required by law and the MSP payment is determined accordingly.

*Comment:* One commenter stated that its state Medicaid system does not utilize the CMS 1450 claim form for hospice elections nor do they make benefit utilization information available to providers and questioned whether Medicaid reimbursement would be changing to a two-tiered system for RHC level of care. A few commenters stated that the Affordable Care Act authorized concurrent care for children, so they could receive hospice services while continuing to receive treatment intended to prolong their lives and was specifically intended to enable children and their parents to access hospice services earlier in the course of disease.

The commenter stated that a reduction in reimbursement for services longer than 60 days could undercut the intent of the concurrent care provision. One commenter asked whether any provisions would be made to facilitate a later implementation date for Medicaid if there is no delay to the October 1, 2015 effective date of the proposals in the proposed rule.

*Response:* Section 2302 of the Affordable Care Act requires states to make hospice services available to children eligible for Medicaid without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition. As a general matter, individuals under age 21 in Medicaid receive all medically necessary services coverable under the mandatory and optional categories in section 1905(a) of the Social Security Act, including hospice. Therefore, payment changes in the Medicaid hospice program should not affect the curative services a child receives. As we noted above, we will finalize a delay in the implementation of both the proposed RHC rates and the proposed SIA payment until January 1, 2016. Between October 1, 2015 and December 31, 2015, hospices will continue to be paid a single FY 2016 RHC per diem payment amount while the operational transition is being finalized at CMS. Effective January 1, 2016, the RHC rates for days 1 through 60 and days 61 and beyond would replace the single RHC per diem payment rate (the RHC per diem rates are listed in section III.C of this final rule). Therefore, the effective date for both Medicare and Medicaid will be January 1, 2016. As we noted above, for Medicare reimbursement, hospices will not be required to change how the bill for RHC days to comply with the proposed higher RHC rate for the first 60 days of care and a lower rate thereafter. CMS' claims processing system will be responsible for the count of days, rather than the individual hospices, and will pay the appropriate rate accordingly. We defer to the states on how they will implement this change in Medicare reimbursement for their state Medicaid programs.

*Comment:* One commenter questioned, with two RHC rates, how CMS and the MACs will determine which RHC payment rate will be applicable when a hospice exceeds the General Inpatient Cap and the rate is changed to the RHC rate.

*Response:* If a hospice's inpatient days (GIP and respite) exceed 20 percent of all hospice days then, for inpatient care, the hospice is paid: (1) The sum of the total reimbursement for inpatient care multiplied by eighty percent, the maximum allowable inpatient days percentage; and (2) The sum of the actual number of inpatient days in excess of the limitation multiplied by the routine home care rate. Since the inpatient cap determination is done in the aggregate and not on an individual claim-by-claim basis, CMS will be using the RHC rate for days 61 and beyond when reconciling payments for hospices that exceed the inpatient cap. Using the RHC rate for days 61 and beyond is the most appropriate RHC rate to use for this purpose since the RHC rate for days 1–60 currently exceeds the inpatient respite care (IRC) payment rate.

*Comment:* One commenter stated that some hospice patients revoke the hospice benefit to pursue curative treatment and then return to the benefit in a matter of days or weeks. Does the 60 day period start and stop with these patient requests?

*Response:* CMS will not count the days in between an election as hospice days. Anytime there is a discharge (patient revocation, patient discharged as no longer terminally ill, patient transfer, patient discharge for cause) the days where the patient was receiving care under the Medicare hospice benefit will be included as part of the hospice day count for the next election, unless the patient does not receive hospice services for 60 consecutive days. As we stated above, we consider a hospice ''episode'' of care to be a hospice election period or series of election periods separated by no more than a 60 day gap in hospice care. However, we note that if a patient is electing the hospice benefit, revoking the hospice benefit to seek curative care, and then re-electing the hospice benefit within a few days, we are concerned about whether these patients are truly appropriate for the hospice benefit and/or whether hospices are fully explaining and obtaining patient acknowledgement of the palliative versus curative nature of hospice care.

*Comment:* One commenter expressed confusion in how CMS calculated the budget neutrality factors for the proposed RHC payment rates in Table 18. The commenter provided a series of tables that used information in Table 16 in an effort to replicate the budget neutrality factor.

*Response:* The commenter was using information in Table 16 to calculate the budget neutrality factor in Table 18 above. Table 16 is used to create the two RHC rates that are budget neutral to one another without the application of area wage adjustment. Once we calculate RHC payments taking into account area wage adjustment, an additional budget neutrality factor is necessary to ensure overall hospice payments remain budget neutral. The footnote for Table 18 above notes that a budget neutrality adjustment to the two RHC rates is required to maintain overall budget neutrality for the hospice benefit due to differences in the average wage index for days 1–60 compared to days 61 and over when making payments based on the two RHC rates, rather than the one RHC rate.

*Comment:* One commenter stated that after the revision to the labor portion applicable to the proposed two RHC rate structure, the labor portion of each rate is now different. The commenter questioned whether CMS would be revising the labor-related share for each of the two proposed RHC rates or whether CMS would still be applying the labor-related share of 68.71 percent to each of the two proposed RHC rates.

*Response:* The calculations in Tables 17 and 18 above make adjustments to the labor portion of the FY 2015 RHC rate to create two new RHC rates based on observed differences in visit intensity (as measured by wage-weighted minutes) between days 1–60 of the hospice episode of care and days 61 and beyond. These calculations were performed to set two RHC rates that sufficiently align with the expected visit intensity differences observed in days 1–60 versus days 61 and beyond in accordance with section 1814(i)(1)(A) of the Act, which requires hospice payment amounts to equal the reasonable cost of providing hospice care. As outlined in Table 19 below, multiplying the labor-portion of the two RHC rates, prior to the budget neutrality adjustment for average wage index differences between days 1–60 and days 61 and beyond, in column 2 of Table 18 above ($137.98 for days 1–60 and $95.49 for days 61+) by the number of respective RHC days (column 2 in Table 19 below), produces the total amount of RHC payments attributable to the labor portion of the two RHC rates. Total RHC payments attributable to the labor portion is equal to the sum of payments for the two RHC rates attributable to the labor portion and likewise for the payments attributable to the non-labor portion. Table 19 below shows the results.

TABLE 19—ESTIMATED RHC LABOR PORTION PAYMENTS, RHC NON-LABOR PORTION PAYMENTS AND TOTAL RHC PAYMENTS FOR DAYS 1–60 AND DAYS 61 AND BEYOND, FY 2015

| | RHC days | Labor portion of payments | Non-labor portion of payments | Total payments |
|---|---|---|---|---|
| Days 1–60 | 28,052,004 | $3,870,615,511.92 | $1,398,672,919.44 | $5,269,288,431.36 |
| Days 61+ | 57,082,561 | 5,450,813,749.89 | 2,846,136,491.46 | 8,296,950,241.35 |
| Total | | 9,321,429,261.81 | 4,244,809,410.90 | 13,566,238,672.71 |

When you divide the amount of total payments attributable to the labor portion of the proposed RHC rates of $9,321,429,261.81 by the amount of total payments of $13,566,238,672.71, the result is 68.71 percent, which is the labor-related share for the RHC rate. Therefore, these calculations do not ultimately change the labor-related share of 68.71 percent that will be used for geographic area wage adjustment required per section 1814(i)(2)(D) of the Act. We will consider changes to the labor-related share for the purposes of geographic wage adjustment once cost report data by level of care is available for analysis.

*Comment:* One commenter asked if CMS performed any analysis on how the proposed RHC rates would impact hospices that exceed their aggregate cap.

*Response:* Yes, CMS did perform analysis on how the proposed RHC payment rates for days 1–60 and days 61 and beyond would impact both hospice providers who did not exceed their aggregate cap in 2013 and for those hospice providers who did exceed their aggregate cap in 2013. For those hospice providers who did not exceed their aggregate cap in 2013, we estimated that the proposed RHC rates would result in a 0.14 percent increase in payments. However, for those hospice providers that exceeded their aggregate cap, hospice payments were estimated to decrease by 5.40 percent.

*Comment:* One commenter objected to payment rates being based, at least in part, on information that has never been audited (cost reports). The commenter implored CMS to develop a strategy to establish a base year and audit hospice cost reports to determine costs for future rate setting and/or further changes in payment methodologies. Another commenter noted that the data used to determine the proposed RHC rates are old data that do not reflect the shift in coverage occurring as a result in the clarification by CMS that hospices are expected to cover ''virtually all'' care. The commenter stated that additional analysis of more recent data is needed to determine a sufficient base rate for RHC.

*Response:* We note that the proposed RHC rates and the proposed SIA payment policy were established based on analysis of visit intensity during a hospice episode of care and visit patterns during the last seven days of life using hospice claims data. As noted above, CMS recently revised the freestanding hospice cost report form for cost reporting periods beginning on or after October 1, 2014. Once the new cost report data are available for analysis, we will be able to analyze hospice costs by level of care. We want to remind hospices that each hospice cost report is required to be certified by the Officer or Administrator of the hospice and that the Hospice Medicare Cost Report (MCR) Form (CMS–1984–14) states the following:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ {Provider Name(s) and Provider CCN(s)} for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

As always, we encourage providers to fill out the Medicare cost reports as accurately as possible.

*Comment:* Some commenters urged CMS to review its policies and payments for CHC and General Inpatient Care (GIP). One commenter stated that both these levels of care are highly abused and used for the wrong reasons. The commenter suggested that CMS require pre-authorization for those two levels of care. The commenter stated that they are pressured to admit patients to GIP at the end of a hospital stay or in a SNF just because they are dying and stated that many nursing homes/hospices/hospitals are operating in this matter. The commenter went on to state that all states should require a Certificate of Need for hospice and all hospices should be non-profit as it is very disturbing to see companies that own nursing homes and hospices gaming payments to increase profits. Other commenters expressed frustration regarding the Notice of Election (NOE) timely filing requirement that was finalized in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452).

*Response:* While these comments are outside the scope of this rule, we thank the commenters for their comments and will take them under consideration for future rulemaking.

*Final Action:* We are finalizing this proposal as proposed with an effective date of January 1, 2016. This delay in implementation from October 1, 2015 to January 1, 2016 will allow for state Medicaid agencies to make the necessary systems and software changes. Between October 1, 2015 and December 31, 2015, hospices will continue to be paid a single FY 2016 RHC per diem payment amount. Effective January 1, 2016, a higher RHC rate for days 1 through 60 of a hospice episode of care and a lower RHC rate for days 61 and beyond of a hospice episode of care will replace the single RHC per diem payment rate (the RHC per diem rates are listed in section III.C of this final rule). An episode of care for hospice RHC payment purposes is a hospice election period or series of election periods separated by no more than a 60 day gap in hospice care. For hospice patients who are discharged and readmitted to hospice within 60 days of that discharge, a patient's prior hospice days would continue to follow the patient and count toward his or her patient days for the new hospice

election. We will calculate the patient's episode day count based on the total number of days the patient has been receiving hospice care separated by no more than a 60 day gap in hospice care, regardless of level of care or whether those days were billable or not. This calculation would include hospice days that occurred prior to January 1, 2016.

3. Service Intensity Add-On (SIA) Payment

Section 1814(i)(1)(A) of the Act states that payment for hospice services must be equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations. In addition, section 1814(i)(6)(D) of the Act, as amended by section 3132(a) of the Affordable Care Act, requires the Secretary to implement revisions to the methodology for determining the payment rates for the RHC level of care and other services included in hospice care under Medicare Part A as the Secretary determines to be appropriate as described in section III.B.1 above. Given that independent analyses demonstrate a U-shaped cost pattern across hospice episodes, CMS believes that implementing revisions to the payment system that align with this concept supports the requirements of reasonable cost in section 1814(i)(A) of the Act.

As articulated in section III.B.1.b above, CMS considered implementing a tiered payment model as described in the FY2014 Hospice Wage Index final rule (78 FR 48271) and in the Hospice Study Technical Report issued in April of 2013,[44] in order to better align payments with observed resource use over the length of a hospice stay. However, operational concerns and programmatic complexity led us to explore the concept of an approach that could be implemented with minimal systems changes that limit reprocessing of hospice claims due to sequential billing requirements. In addition, while the tiered model represented a move toward better aligning payments with resource use, it only accounted for whether skilled services were provided in the last 2 days of life (Groups 5 and 6 in Table 13 above). Section III.B.1.c, above notes that on any given day during the first 7 days of a hospice election and last 7 days of life, only about 50 percent of the time are visits being made. In our view, increasing payments at the end of life for days where visits are not occurring does not align with the requirements of reasonable cost articulated in statute in section 1814(i)(A) of the Act. Therefore, as one of the first steps in addressing the observed misalignment between resource use and associated Medicare payments and in improving patient care through the promotion of skilled visits at end of life with minimal claims processing systems changes, CMS proposed to provide an SIA payment if the conditions outlined below are satisfied.

To qualify for the SIA payment, the following criteria must be met: (1) The day is a RHC level of care day; (2) the day occurs during the last 7 days of life (and the beneficiary is discharged dead); and, (3) direct patient care is provided by a RN or a social worker (as defined by § 418.114(c) and § 418.114(b)(3), respectively) that day. The SIA payment will be equal to the CHC hourly payment rate (the current FY 2015 CHC rate is $38.75 per hour), multiplied by the amount of direct patient care provided by a RN or social worker for up to 4 hours total, per day, as long as the three criteria listed above are met. The SIA payment will be paid in addition to the current per diem rate for the RHC level of care.

CMS will create two separate G-codes for use when billing skilled nursing visits (revenue center 055x), one for a RN and one for a Licensed Practical Nurse (LPN). During periods of crisis, such as the precipitous decline before death, patient needs intensify and RNs are more highly trained clinicians with commensurately higher payment rates who can appropriately meet those increased needs. Moreover, our rules at § 418.56(a)(1) require the RN member of the hospice interdisciplinary group to be responsible for ensuring that the needs of the patient and family are continually assessed. We expect that at end of life, the needs of the patient and family will need to be frequently assessed; thus the skills of the interdisciplinary group RN are required.

We note that social workers also often play a crucial role in providing support for the patient and family when a patient is at end of life. While the nature of the role of the social worker does facilitate interaction via the telephone, CMS will only pay an SIA for those social work services provided by means of in-person visits. Analysis conducted by Abt Associates on the FY 2013 hospice claims data shows that in the last 7 days of life only approximately 10 percent of beneficiaries received social work visits of any kind. Moreover, we also found that only about 13 percent of social work ''visits'' are provided via telephone; therefore, the proportion of social work calls likely represents a very small fraction of visits overall in the last few days of life. The SIA payment will be in addition to the RHC payment amount. The costs associated with social work phone conversations; visits by LPNs, hospice aides, and therapists; counseling; drugs; medical supplies; DME; and any other item or service usually covered by Medicare will still be covered by the existing RHC payment amount in accordance with section 1861(dd)(1) of the Act.

In 2011, the OIG published a report that focused specifically on Medicare payments to hospices that served a high percentage of nursing facility residents. The OIG found that from 2005 to 2009, the total Medicare spending for hospice care for nursing facility residents increased from $2.55 billion to $4.31 billion, an increase of almost 70 percent (OIG, 2011). When looking at hospices that had more than two-thirds of their beneficiaries in nursing facilities, the OIG found that 72 percent of these facilities were for-profit and received, on average, $3,182 more per beneficiary in Medicare payments than hospices overall. High-percentage hospices were found to serve beneficiaries who spent more days in hospice care, to the magnitude of 3 weeks longer than the average beneficiary. In addition, when looking at distributions in diagnoses, OIG found that high-percentage hospices enrolled beneficiaries who required less skilled care. In response to these findings, OIG recommended that CMS modify the current hospice reimbursement system to reduce the incentive for hospices to seek out beneficiaries in nursing facilities, who often receive longer but less complex and costly care.[45] Given the OIG recommendation, CMS proposed excluding SNF/NF sites of service from eligibility for the SIA payment.

The for-profit provider community has frequently highlighted its concerns regarding the lack of adequate reimbursement for hospice short stays in its public filings with the Securities and Exchange Commission (SEC) as described in MedPAC's 2008 Report to Congress.[46] Specifically, MedPAC cited records from the SEC for publicly traded for-profit hospice chains as evidence of a general acknowledgement of the nonlinear cost function of resource use within hospice episodes. For instance:

[44] *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Study-Technical-Report.pdf.*

[45] *http://oig.hhs.gov/oei/reports/oei-02-10-00070.pdf.*

[46] *http://www.medpac.gov/documents/reports/Jun08_Ch08.pdf.*

• VistaCare: ''Our profitability is largely dependent on our ability to manage costs of providing services and to maintain a patient base with a sufficiently long length of stay to attain profitability,'' and that ''cost pressures resulting from shorter patient lengths of stay . . . could negatively impact our profitability.'' [47]

• Odyssey HealthCare: ''Length of stay impacts our direct hospice care expenses as a percentage of net patient service revenue because, if lengths of stay decline, direct hospice care expenses, which are often highest during the earliest and latter days of care for a patient, are spread against fewer days of care.'' [48]

Short lengths of stay were also cited as a source of financial difficulties for small rural hospices (implying that longer stays were more profitable).[49] In the FY 2014 Hospice Wage Index and Payment Rate Update proposed rule, we stated that ''analysis conducted by Abt Associates found that very short hospice stays have a flatter curve than the U-shaped curve seen for longer stays, and that average hospice costs are much higher. These short stays are less U-shaped because there is not a lower-cost middle period between the time of admission and the time of death.'' The FY 2014 Hospice Wage Index and Payment Rate Update proposed rule went on to note that a ''short stay add-on'' was under consideration as a possible reform option (78 FR 27843). Public comments received in response to the proposed rule were favorable regarding a possible short stay add-on payment.

Since the SIA payment will be applicable to any 7-day period of time ending in a patient's death, hospice elections with short lengths of stay are eligible to receive an additional payment that will help mitigate the marginally higher costs associated with short lengths of stay, consistent with the 'reasonable cost' structure of the hospice payment system. For FY 2013, 32 percent of hospice stays were 7 days or less with 60 percent of stays lasting 30 days or less. The median length of stay in FY 2013 was 17 days.

Although Figure 4 above demonstrates that there is increased resource use during the first 2 days of an election, we are not proposing an additional SIA payment for the first or second day of a hospice election when the length of stay is beyond 7 days. The SIA payment for the last 7 days of life will provide additional reimbursement to help to mitigate the higher costs for stays lasting less than the median length of stay, where spreading out the initial costs of the first 2 days of the election over a smaller number of days may not be enough to make the overall stay profitable. Any stay of 7 days or less before death will be eligible for SIA payment on all RHC days.

We believe that the SIA payment would help to address MedPAC and industry concerns regarding the visit intensity at end of life and the concerns associated with the profitability of hospice short stays. The RHC rates described in section III.B.2 above and SIA payment will advance hospice payment reform incrementally, as mandated by the Affordable Care Act while simultaneously maintaining flexibility for future refinements. Since this approach will be implemented within the current constructs of the hospice payment system, no major overhaul of the claims processing system or related claims/cost report forms will be required, minimizing burden for hospices as well as for Medicare.

As required by Section 1814(i)(6)(D)(ii) of the Act, any changes to the hospice payment system must be made in a budget neutral manner in the first year of implementation. Based on the desire to improve patient care through the promotion of skilled visits at end of life, regardless of the patient's lifetime length of stay, we proposed that the SIA payments would be budget neutral through a reduction to the RHC rates. The SIA payment budget neutrality factor (SBNF) used to reduce the RHC rates is outlined in section III.C.3.

Finally, we solicited public comment on all aspects of the SIA payment as articulated in this section as well as the corresponding changes to the regulations at § 418.302 in section VI. We also proposed changing the word ''Intermediary'' to ''Medicare Administrative Contractor'' in the regulations text at § 418.302 and technical regulations text changes to § 418.306 as described in section VI.

Summaries of the public comments and our responses to comments on all aspects of the SIA payment are summarized below:

*Comment:* Nearly all commenters support the implementation of the SIA payment policy, stating that the need for skilled direct patient care and support is greater at end of life, causing an increase in hospice costs. Many commenters further suggested that implementation occur as soon as possible and appreciate the opportunity for incremental payment reform.

*Response:* We thank the commenters for their support. We agree that our proposal helps to reinforce the provision of skilled direct patient care when the need is greater at end of life.

*Comment:* Several commenters suggested that services provided by chaplains and other spiritual care counselors should be eligible for the SIA payment. In addition, several commenters asked whether services provided by LPNs, hospice aides, and other professionals (therapists, etc.) would be covered under the SIA payment provisions. Many commenters note that the services provided by LPNs are currently covered in the CHC level of care. One commenter asked if visits for the pronouncement of death will be considered eligible for the SIA payment.

*Response:* While we acknowledge the tremendous value delivered by spiritual care counseling and other disciplines during hospice episodes, Section 1814(i)(1)(A) of the Act explicitly precludes Medicare payment for bereavement counseling and other counseling services (including nutritional and dietary counseling) as separate services. Therefore, no payment will be extended for those services under the SIA policy. While CMS recognizes that the services rendered by all hospice professionals, including LPNs, are extremely valuable, the primary goal of the SIA policy is to promote the highest-quality, skilled care to beneficiaries at the end of life. Given that RNs provide higher-skilled services, as required by CMS's Conditions of Participation, and social workers provide a skilled level of support for both the patient and family, CMS will only pay an SIA amount for those services rendered by RNs and social workers. CMS will not pay an SIA amount for those services rendered by other professionals. The base RHC rate is intended to cover other skilled and non-skilled services that may be needed at the end of life. However, at the end of life, where a rapid decline is often expected, patient and family needs intensify and typically there are frequent care plan changes necessitating the immediate need for RN and SW services. In accordance with the hospice CoPs, an RN, and not an LPN, is required to be part of the hospice IDT to provide coordination of care and to ensure continuous assessment of the patient. Therefore, to ensure continuous

[47] Health Care Strategic Management. 2004. Hospice companies benefit from favorable Medicare rates. Health Care Strategic Management 22, no. 1: 13–14.

[48] Odyssey HealthCare, Inc. 2004. Annual report to shareholders, form 10–K. Filed with the Securities and Exchange Commission, Washington, DC, March 11. Dallas, TX: Odyssey HealthCare, Inc.

[49] Virnig, B. A., I. S. Moscovice, S. B. Durham, et al. 2004. Do rural elders have limited access to Medicare hospice services? Journal of the American Geriatrics Society 52, no. 5: 731–735.

assessment and coordination of care at the very end of life, the skills of an RN would be needed and we believe hospices should be encouraged to meet the needs of the patient and family. Additionally, given commenters' overwhelming support for incremental payment reform, CMS hopes to advance hospice payment changes over time; therefore, in the future, we will re-evaluate whether the inclusion of services provided by LPNs for the SIA is warranted and re-assess the policies and payments around the CHC level of care as well as other facets of the Medicare Hospice Benefit.

*Comment:* Several commenters noted that they are concerned that setting the SIA add-on payment equal to the CHC hourly payment rate multiplied by the amount of direct patient care up to 4 hours total per day does not adequately cover the cost of hospice care, especially for individuals with certain diagnoses related to their terminal illness. The commenters also noted that the Continuous Home Care Payment rate currently has a minimum 8 hour requirement to meet these complex needs. One commenter asked if the CHC level of care could still be provided in the last 7 days of an episode.

*Response:* The primary purpose of the SIA payment is to promote visits during the end of life and account for the associated increased resources required. We believe that using the CHC hourly payment rate is a reasonable proxy for the costs of providing such care. The CHC level of care will still be available to both beneficiaries and providers, as the patient's status dictates. For the purposes of the SIA payment, the claims processing systems will evaluate all 7 days prior to death. If any of the days meet the eligibility criteria (RHC level of care with appropriate staffing, etc.), then those days will be eligible for the SIA payment. Other levels of hospice care are still eligible for payment as appropriate. Given that CMS intends to promote direct patient care in the 7 days prior to death, visits for the pronouncement of death will not be included as eligible visits for SIA payments. As CMS collects more data related to the costs of providing care, specifically data included in the newly-revised cost reports, we will reassess the appropriate payment level for all aspects of the hospice payment system, including the SIA payment as well as the four levels of care.

*Comment:* Several commenters suggested that hospices should be given the opportunity to provide additional RN and social work services approved by the patient's physician in order to deliver more than 4 hours of RN or social work time and receive payment for these additional service hours. One commenter requested clarification regarding the payment for services for concurrent care from both a RN and social worker during the last 7 days of life.

*Response:* While we understand the interest in providing a SIA payment for services beyond the 4 hour threshold established by the SIA policy, we do believe that the RHC rate level of care plus the SIA payment for services up to 4 hours will provide sufficient payment to cover the increased cost of patient care. If a patient's needs intensify further, requiring more intensive supports, hospices will still be able to provide the CHC level of care for 8 hours of service and beyond as well as utilize the other levels of hospice care as appropriate. CMS acknowledges that there may be a need for concurrent care from both an RN and a social worker during the days preceding death. The natures of the two disciplines are distinct, and we acknowledge that the RN may need to focus on the clinical aspects of the patient while the social worker meets separately with the family and others to process anticipatory grief. Therefore, concurrent services will be eligible for the SIA payment, according to the criteria outlined above.

*Comment:* Many commenters had concerns regarding the ''billing'' of SIA days and requested clarification of the provider's responsibility for ''billing'' days for the SIA payment. In addition, several commenters requested clarification on the time increments provided by the RN and social workers that would be eligible for the SIA payment, asking for detail on whether or not service should be tracked in 15 minute increments. One commenter asked how the SIA payment will apply if a patient's last 7 days of life spans 2 months. Another commenter questioned whether CMS has the time, energy, and staff to review all claims for appropriate distribution of SIA payments.

*Response:* Hospices will continue to submit claims with revenue center lines appropriately noted in appropriate increments. CMS' claims processing system will assess the last 7 days of services before end of life and determine if the RHC level of care was provided on any of those 7 days, regardless of other levels of care also provided during that period. We acknowledge that the term 'billing' may have been misleading. Hospices should submit claims per the established protocols, and the claims processing system will determine the SIA payment eligibility of the 7 days preceding death. For eligible stays, the SIA payment will be calculated by the number of hours (in 15 minute increments) of service provided by an RN or social worker during last 7 days of life for a minimum of 15 minutes and up to 4 hours total per day. CMS appreciates the concern regarding the appropriate disbursement of SIA payments. We will be working with our operational staff and contracting partners in order to fully automate the review of claims with a discharge of death in order to identify eligible visits and generate appropriate SIA outlays.

*Comment:* Several commenters recommended that CMS include episodes in SNF/NF as eligible for the SIA payment. The commenters stated that the needs of dying patients were not specific to any particular physical location. Commenters stated that more intensive services are merited in any 'home' setting. Additionally, commenters noted that the Medicare Conditions of Participation for hospices require the provision of the same level of care and service to patients, regardless of setting.

*Response:* We agree that the payment of the SIA for additional RN and SW services during the last 7 days of life in these settings is appropriate and thus we are finalizing a policy that pays the SIA payment for patients that reside in a SNF/NF. We will monitor the SIA based on claims data and continue to investigate whether a differential site of service payment could be an appropriate mechanism to address OIG and MedPAC concerns.

*Comment:* One commenter asked whether the SIA payment policy will apply for both new and existing hospice elections. Several commenters asked if different or additional documentation would be required for SIA visits. Some commenters suggested that criteria be developed demonstrating the need for additional hours per day similar to the protocols around CHC. Such documentation could potentially require that the clinician document why additional hours are needed. Several commenters expressed concern that hospice providers may begin making 'unnecessary' visits to hospice patients at the end of life in order to capitalize on potential SIA payments. The same commenters further suggested that CMS not use an SIA-type payment approach but instead utilize a high RHC rate for the last 7 days of life.

*Response:* Both new and existing hospice elections will be eligible for the SIA payment, as long as the criteria for the add-on are met. No additional documentation will be required in order to receive the SIA payment. The Medicare claims processing system will evaluate the days within a hospice

election for SIA eligibility and calculate the add-on payment accordingly. We appreciate the concern that some hospices may attempt to capitalize on extra payments made possible through the SIA policy. CMS will certainly continue to monitor hospice behavior for any concerning patterns as well as any impact to future payment updates. However, we maintain that providing payment for increased services at the end of life is consistent with the goal of responding to and providing for intensified patient needs. Conversely, paying an increased RHC rate for the last 7 days of life regardless of whether or not skilled visits (RN or social worker) are provided would not encourage the hospice to schedule skilled visits during that timeframe. With this SIA policy, we strive to encourage the hospice to provide skilled care in a patient's most intense moments of need by dispersing additional payment for actual services rendered by the appropriate skilled staff.

*Comment:* Several commenters raised concerns regarding the criteria that the RN and SW visit be an in-person visit in order to be reimbursable, stating that there are many hospice patients in rural and frontier areas that require long travel times for hospice staff. The commenters stated that telephone interaction becomes an important part of the hospice service and suggested that as long as hospice providers document the reason for the telephone call versus an in-person visit the call should be reimbursable.

*Response:* We appreciate the comments regarding the value of hospice social work services provided via the telephone. CMS recognizes that this support is vital and provides needed assistance in crucial circumstances. However, the primary purpose of the SIA payment is to encourage direct patient care in the last days of life. Therefore, CMS will only be paying the SIA payment for those services provided directly to the patient in his/her last week of life by an RN or SW in his or her home setting.

*Comment:* Several commenters noted their support for CMS' proposal to continue to make the SIA payments budget neutral in future years through annual determination of the Service Intensity Add-On Budget Neutrality Factor (SBNF) based on the most current and complete fiscal year utilization data available at the time of rulemaking.

*Response:* We appreciate the support of our budget neutrality approach for the SIA payment policy proposal. We believe that this will help to create an incentive in the longer term for the provision of services in patients' moments of most intensive need.

*Comment:* Several commenters stated that CMS should provide stakeholders adequate time to test, assess, perform necessary software updates, receive education, and provide feedback on changes due to the SIA payments, either by delaying its implementation or initiating a pilot program before applying the policy across all providers. Many commenters noted concern over the potential impact of the SIA payment proposal to state Medicaid programs, which are currently unprepared for the transition to this payment methodology and would need time to prepare for this significant change.

*Response:* CMS has been working with our contractors to develop systems changes to the fullest extent possible in parallel with the development of this rule. Our system maintainers will have their full software development lifecycle to implement these changes. We do not have concerns about the readiness of Medicare systems on October 1, 2015. Regarding hospice system changes, we do not anticipate that this rule will require any changes to hospice billing instructions so systems for submitting claims and receiving Medicare payment should not be affected and the need for retraining billing staff should be limited, but hospices may need to change their internal accounting systems. However, given the delay in the implementation date for the two RHC rates in section III.B.2 above, CMS will delay the effective date of the SIA policy to January 1, 2016 in order to better coordinate implementation of hospice payment reforms.

*Comment:* Several commenters noted concern that the length of stay for a beneficiary is out of the patient's control and should not be factored into the SIA. Additionally, several commenters further noted that hospice providers will not likely be able to forecast an accurate and reliable operating budget to include the proposed 7 day payment add-on at the patient's end of life.

*Response:* CMS appreciates that the nature of the hospice population leads to difficulty in prognosticating the required length of services. However, the SIA payment policy is meant to encourage visits in the last 7 days of life, regardless of the length of stay, so an episode will be eligible for the payment regardless of the patient's overall total days in hospice care. Moreover, CMS notes that the expectation is that providers would be supplying the needed services to patients during the RHC and other levels of care, regardless of budgeting prognostication for any potential SIA payment amounts.

*Comment:* A few commenters expressed concern over the two proposed SIA budget neutrality factors, stating that the proposed budget neutrality factor for days 61 and beyond is higher than that of days 1–60, leading to a greater reduction to the High RHC rate for days 1–60. The commenters argue that a single SIA budget neutrality factor would yield a more equitable overall reduction with less of a decrease to the higher RHC rate.

*Response:* CMS appreciates the feedback regarding the application of the SIA budget neutrality factors. Because of the interaction between the SIA payment policy and the two RHC rates, we believe that it is appropriate that two factors be generated for each rate, maintaining a budget neutral system for the whole of the Medicare hospice benefit, so that our rates accurately align with and account for resource use differences during the first 60 versus days 61 and beyond of hospice care. However, CMS will consider this and other refinements to the policy for future payment and policy updates.

*Comment:* Several commenters suggested that CMS should increase its oversight of hospice providers not delivering the services required under the Hospice Conditions of Participation and exhibiting inappropriate practices highlighted by the OIG and the MedPAC.

*Response:* CMS appreciates the encouragement to continue overseeing and monitoring provider behavior for questionable activity. CMS is committed to encouraging providers to supply the best quality care in the most appropriate ways, and we will continue to work to incentivize and monitor for the most appropriate practices in the hospice provider community.

*Comment:* Several commenters requested information regarding the forthcoming G-codes that will be used to differentiate LPN and RN services. One commenter suggested that CMS provide detailed instructions and answer operational questions in this final rule as opposed to Change Requests, Medicare Learning Network articles, and other sub-regulatory guidance as is the typical process.

*Response:* Per the CMS protocols, the details regarding these newly-created G-codes will be forthcoming through the established Change Request process. CMS appreciates the desire for more education regarding the SIA; however, we will continue to utilize the established means to convey the systems changes as well as to educate the provider community regarding the policy and operational changes.

*Comment:* One commenter requested that CMS continue to evaluate cost data in order to identify any trends in 'co-factors' that may be related to service intensity at the end of life, such as visits from the Spiritual Care Coordinator and other disciplines, and propose further adjustments as data directs.

*Response:* CMS will continue to monitor and analyze data related to the cost of providing care in the hospice population. We will re-evaluate policies and payments in accordance to observed trends in the cost and other data gathered so long as it does not violate the Act.

*Comment:* One commenter requested that CMS consider paying the SIA to those hospices that receive a transfer hospice patient from another provider, as this additional funding could help mitigate the receiving hospice's costs for starting care.

*Response:* CMS recognizes that a hospice who receives a transfer hospice patient may experience increased start-of-care costs. However, we are not proposing to provide SIA payments at the start of an episode. We believe that the SIA payment coupled with the new RHC rates finalized in section III.B.2 above, provide sufficient payment for the delivery of hospice care.

*Final Action:* We are finalizing the SIA proposal as proposed; however, we will include episodes in SNF/NF as eligible for the SIA payment. We are finalizing the SIA proposal with an effective date of January 1, 2016 in order to better coordinate implementation of the hospice payment reforms, including the finalization of the new RHC rates discussed in section III.B.2 above. Finally, we will also finalize our proposal to continue to make the SIA payments budget neutral through an annual determination of the SBNF, which will then be applied to the RHC payment rates. The SBNF for the SIA payments will be calculated for each FY using the most current and complete fiscal year utilization data available at the time of rulemaking.

### *C. FY 2016 Hospice Wage Index and Rate Update*

#### 1. FY 2016 Hospice Wage Index

##### a. Background

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

We use the previous fiscal year's hospital wage index data to calculate the hospice wage index values. We have consistently used the pre-floor, pre-reclassified hospital wage index to derive the hospice wage index. For FY 2016, the hospice wage index will be based on the FY 2015 hospital pre-floor, pre-reclassified wage index. This means that the hospital wage data used for the hospice wage index is not adjusted to take into account any geographic reclassification of hospitals including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or Inpatient Respite Care (IRC).

In the FY 2006 Hospice Wage Index final rule (70 FR 45130), we adopted the revised labor market area definitions as discussed in the OMB Bulletin No. 03–04 (June 6, 2003). This bulletin announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas. The bulletin is available online at *http://www.whitehouse.gov/omb/bulletins/b03-04.html*. In adopting the CBSA geographic designations for FY 2006, we provided for a 1-year transition with a blended wage index for all providers. For FY 2006, the wage index for each geographic area consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index. Since the expiration of this 1-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

When adopting OMB's new labor market designations in FY 2006, we identified some geographic areas where there were no hospitals, and thus, no hospital wage index data, which to base the calculation of the hospice wage index. In the FY 2010 Hospice Wage Index final rule (74 FR 39386), we also adopted the policy that for urban labor markets without a hospital from which hospital wage index data could be derived, all of the CBSAs within the state will be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. In FY 2016, the only CBSA without a hospital from which hospital wage data could be derived is 25980, Hinesville, Georgia.

In the FY 2008 Hospice Wage Index final rule (72 FR 50214), we implemented a new methodology to update the hospice wage index for rural areas without a hospital, and thus no hospital wage data. In cases where there was a rural area without rural hospital wage data, we used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. The term ''contiguous'' means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, our policy of imputing a rural pre-floor, pre-reclassified hospital wage index based on the pre-floor, pre-reclassified hospital wage index (or indices) of CBSAs contiguous to a rural area without a hospital from which hospital wage data could be derived does not recognize the unique circumstances of Puerto Rico. For FY 2016, we will continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

##### b. Elimination of the Wage Index Budget Neutrality Factor (BNAF)

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 were then subject to either a budget neutrality adjustment or 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 were adjusted by either: (1) The hospice BNAF; or (2) the hospice floor—a 15 percent increase subject to a maximum wage index value of 0.8; whichever results in the greater value.

The FY 2010 Hospice Wage Index rule finalized a provision to phase-out the BNAF over 7 years, with a 10 percent reduction in the BNAF in FY 2010, and an additional 15 percent reduction in each of the next 6 years, with complete phase out in FY 2016 (74 FR 39384). As discussed in the proposed rule, (80 FR 25860), the hospice BNAF for FY 2016 is reduced by an additional and final 15 percent for a cumulative reduction of 100 percent. Therefore, for FY 2016, the BNAF is completely phased-out and eliminated.

Hospital wage index values which are less than 0.8 are still subject to the hospice floor calculation. The hospice floor equates to 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.

c. Implementation of New Labor Market Delineations

OMB has published subsequent bulletins regarding CBSA changes. On February 28, 2013, OMB issued OMB Bulletin No. 13–01, announcing revisions to the delineation of MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineation in these areas. A copy of this bulletin is available online at: *http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf*. This bulletin states that it ''provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246–37252) and Census Bureau data.''

Overall, we believe that implementing the new OMB delineations will result in wage index values being more representative of the actual costs of labor in a given area. Among the 458 total CBSA and statewide rural areas, 20 (4 percent) will have a higher wage index using the newer delineations. However, 34 (7.4 percent) will have a lower wage index using the newer delineations. Therefore, to remain consistent with the manner in which we ultimately adopted the revised OMB delineations for FY 2006 (70 FR 45138), we are implementing a 1-year transition to the new OMB delineations. Specifically, we will apply a blended wage index for 1 year (FY 2016) for all geographic areas that will consist of a 50/50 blend of the wage index values using OMB's old area delineations and the wage index values using OMB's new area delineations. That is, for each county, a blended wage index will be calculated equal to 50 percent of the FY 2016 wage index using the old labor market area delineation and 50 percent of the FY 2016 wage index using the new labor market area delineation. This results in an average of the two values. We refer to this blended wage index as the FY 2016 hospice transition wage index.

This 1-year transition policy is also consistent with the transition policies adopted by both the FY 2015 SNF PPS (79 FR 25767) and the CY 2015 HH PPS (79 FR 66032). This transition policy will be for a 1-year period, going into effect on October 1, 2015, and continuing through September 30, 2016. Thus, beginning October 1, 2016, the wage index for all hospice payments will be fully based on the new OMB delineations.

The wage index applicable to FY 2016 is available as a wage index file on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.* The wage index will not be published in the **Federal Register**. The hospice wage index for FY 2016 will be effective October 1, 2015 through September 30, 2016.

The wage index file provides a crosswalk between the FY 2016 wage index using the current OMB delineations in effect in FY 2015 and the FY 2016 wage index using the revised OMB delineations, as well as the transition wage index values that will be in effect in FY 2016. The wage index file shows each state and county and its corresponding transition wage index along with the previous CBSA number, the new CBSA number, and the new CBSA name.

Due to the way that the transition wage index is calculated, some CBSAs and statewide rural areas may have more than one transition wage index value associated with that CBSA or rural area. However, each county will have only one transition wage index. For counties located in CBSAs and rural areas that correspond to more than one transition wage index value, the CBSA number will not be able to be used for FY 2016 claims. In these cases, a number other than the CBSA number will be necessary to identify the appropriate wage index value on claims for hospice care provided in FY 2016. These numbers are five digits in length and begin with ''50.'' These codes are shown in the last column of the wage index file in place of the CBSA number where appropriate. For counties located in CBSAs and rural areas that still correspond to only one wage index value, the CBSA number will still be used.

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

*Comment:* Several commenters support the use of the revised OMB CBSA delineations, which incorporate the 2010 Census data for FY 2016 and the proposed transition methodology that would apply a blended wage index for 1 year (FY 2016) for all geographic areas that would consist of a 50/50 blend of the wage index values using OMB's old area delineations and the wage index values using OMB's new area delineations. We received a few comments regarding the transition to the new delineations requesting a longer transition period or clarification of the transition year. One commenter requests that CMS review the impact this has on provider reimbursement and determine if changes need to be made beyond the 1 year transition period.

*Response:* We appreciate the commenters' support of the new delineations which will be incorporated into hospice reimbursement beginning in FY 2016. We established the use of the latest OMB delineations that are available since FY 2006 (70 FR 45138) in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. We also agree that applying 50/50 blend of the wage index values using OMB's old area delineations and the wage index values using OMB's new area delineations for 1 year is an appropriate transition policy. We incorporated the CBSAs for FY 2006 using a 1-year transition policy and we continue to believe that 1 year is an appropriate length of time to transition to the new area delineations.

In order to determine the 50/50 blended wage index for FY 2016, we calculate the wage index values for each county by adding the wage index value under the county's old area delineation with the wage index value under the county's new area delineation. Then, we divide by two. The wage index values for each county may be found in the wage index file located at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.* For claim submission, hospices will use either the CBSA code or the special 50xxx number found in column L of the wage index file. The special 50xxx numbers will be applicable to FY 2016 claims only. Hospices need to use the correct CBSA or alternate 50xxx number. Our claims processing systems will match the correct wage index with the CBSA or alternate 50xxx number submitted on the claim. Hospices will not need to calculate the transition wage

index. Once the 1-year transition to the new area delineations is over, the 50xxx numbers will not be needed. We provide an impact analysis in Section V. ''Regulatory Impact Analysis'' of this final rule. At this time, our impact analysis does not lead us to conclude that changes need to be made beyond the 1 year transition period.

*Comment:* A commenter notes that hospices that serve more than one county may see large variations in the wage index even though the hospice pays standardized wages for all of their staff. We received a comment expressing concerns that the reduction in the wage index does not align with local market pressure. The commenter states that hospice wages and benefits are not reflective of those in hospitals and would like to see an approach focused solely on hospice data and trends. A commenter believes that the use of the hospital wage index methodology for both the hospice and home health benefits creates payment inaccuracies that, unlike those applied to hospitals, are not subject to correction through a reclassification process. The commenter urges CMS to take action to create a fair and level playing field through reform of the wage index process.

*Response:* For many years, hospices have been able to manage their business operations (including staff compensation) while receiving different reimbursements based on serving patients in a variety of locales which have differing wage indexes. Developing a wage index that utilizes data specific to hospices would require us to engage resources in an audit process. In order to establish a hospice specific wage index, we would need to collect data that is specific to hospices. This is not currently feasible due to the volatility of existing hospice wage data and the significant amount of resources that would be required to assess the quality of that data. Furthermore, hospices have expressed concerns over the past few years with recent data collection efforts to support payment reform, the Hospice Item Set Quality Reporting Program, and the CAHPS® Hospice Survey. At this time, we are not collecting hospice specific wage data that may place an additional burden on hospices. We continue to believe that in the absence of hospice or home health specific wage data, using the pre-floor, pre-reclassified hospital wage data is appropriate and reasonable for hospice reimbursement purposes.

The regulations that govern hospice reimbursement do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor provisions that exist for IPPS hospitals. The rural floor provision in section 4410 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) is specific to hospitals. The reclassification provision found in section 1886(d)(10) of the Act is also specific to hospitals. CMS is exploring opportunities to reform the hospital wage index. We refer readers to the CMS Web site at: *www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html*).

*Comment:* A commenter believes that hospices in rural and frontier areas incur higher labor costs due to the need for staff to travel long distances. The commenter encourages CMS to analyze the impact of the change in the wage index area delineations especially on labor costs for hospices in rural and frontier areas.

*Response:* We appreciate the commenter's recommendation. Based on the limited hospice cost report data, we do not have the ability to determine whether an add-on or an adjustment to account for labor costs in different geographic areas would be appropriate at this time.

*Comment:* Commenters protest using CBSAs to determine the wage index for hospice and suggest that we discontinue the use of CBSAs. These commenters specifically mention Montgomery County, Maryland in their comments. Commenters stated that in the ten years since CMS has used CBSAs to determine payment, Montgomery Hospice has received lower payments than neighboring hospices in the Washington–Arlington–Alexandria, DC–VA–MD, WV CBSA. These commenters believe that Montgomery County has a similar cost of living compared to Washington, DC and that Montgomery County shares the same labor market when competing for labor. Therefore, commenters state that hospices in Montgomery County should be reimbursed at the same level as hospices in the Washington, DC area. Commenters stated that Montgomery County should be paid similarly to Washington, DC due to close commuting ties with the District and also due to the fact that Montgomery County is contiguous with Washington, DC. A commenter also protests the use of CBSAs to determine the wage index, specifically in Montgomery County, also notes that OMB cautions agencies concerning the use of the geographic area delineations in non-statistical programs.

*Response:* In the FY 2005 proposed rule (70 FR 22394), we indicated that the MSA delineations as well as the CBSA delineations are determined by the OMB. The OMB reviews its Metropolitan Area definitions preceding each decennial census to reflect recent population changes. We also indicated in the proposed rule, that we believed that the OMB's CBSA designations reflect the most recent available geographic classifications and were a reasonable and appropriate way to define geographic areas for purposes of wage index values. Ten years ago, in our FY 2006 Hospice Wage Index final rule (70 FR 45130), we finalized the adoption of the revised labor market area definitions as discussed in the OMB Bulletin No. 03–04 (June 6, 2003). In the December 27, 2000 **Federal Register** (65 FR 82228 through 82238), OMB announced its new standards for defining metropolitan and micropolitan statistical areas. According to that notice, OMB defines a CBSA, beginning in 2003, as ''a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. The general concept of the CBSAs is that of an area containing a recognized population nucleus and adjacent communities that have a high degree of integration with that nucleus. The purpose of the standards is to provide nationally consistent definitions for collecting, tabulating, and publishing Federal statistics for a set of geographic areas. CBSAs include adjacent counties that have a minimum of 25 percent commuting to the central counties of the area. This is an increase over the minimum commuting threshold for outlying counties applied in the previous MSA definition of 15 percent.

Based on the OMB's current delineations, as described in the February 28, 2013 OMB Bulletin No. 13–01, Montgomery County (along with Frederick County, Maryland) belongs in a separate CBSA from the areas defined in the Washington–Arlington–Alexandria, DC–VA CBSA. Unlike IPPS, IRF, and SNF, where each provider uses a single CBSA, hospice agencies may be reimbursed based on more than one wage index. Payments are based upon the location of the beneficiary for routine and continuous home care or the location of the agency for respite and general inpatient care. It is very likely that hospices in Montgomery County, Maryland provide RHC and CHC to patients in the ''Washington-Arlington-Alexandria, DC–VA'' CBSA in addition to serving patients in the ''Baltimore-Columbia-Towson, Maryland'' CBSA.

While CMS and other stakeholders have explored potential alternatives to

the current CBSA-based labor market system (we refer readers to the CMS Web site at: *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html*), no consensus has been achieved regarding how best to implement a replacement system. As discussed in the FY 2005 IPPS final rule (69 FR 49027), ''While we recognize that MSAs are not designed specifically to define labor market areas, we believe they do represent a useful proxy for this purpose.'' We further believe that using the most current OMB delineations will increase the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels. We have reviewed our findings and impacts relating to the new OMB delineations, and have concluded that there is no compelling reason to further delay implementation. We are implementing the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13–01 for the hospice wage index effective beginning in FY 2016.

We recognize that the OMB cautions that the delineations should not be used to develop and implement Federal, state, and local nonstatistical programs and policies without full consideration of the effects of using these delineations for such purposes. The OMB states that, ''In cases where there is no statutory requirement and an agency elects to use the Metropolitan, Micropolitan, or Combined Statistical Area definitions in nonstatistical programs, it is the sponsoring agency's responsibility to ensure that the definitions are appropriate for such use. When an agency is publishing for comment a proposed regulation that would use the definitions for a nonstatistical purpose, the agency should seek public comment on the proposed use.''

While we recognize that OMB's geographic area delineations are not designed specifically for use in non-statistical programs or for program purposes, including the allocation of Federal funds, we continue to believe that the OMB's geographic area delineations represent a useful proxy for differentiating between labor markets and that the geographic area delineations are appropriate for use in determining Medicare hospice payments. In implementing the use of CBSAs for hospice payment purposes in our FY 2006 rule (70 FR 45130), we considered the effects of using these delineations. We have used CBSAs for determining hospice payments for ten years (since FY 2006). In addition, other provider types, such as IPPS hospital, home health, SNF, inpatient rehabilitation facility (IRF), and the ESRD program, have used CBSAs to define their labor market areas for the last decade.

*Comment:* A commenter noted that in Table 20 of the proposed rule (80 FR 25862), the state attributed to a county listed under CBSA 41540 ''Salisbury, MD–DE'' is incorrect.

*Response:* We thank the commenter for bringing this error to our attention. Worcester County, Maryland is part of CBSA 41540. We made a typographical error when we referred to Worcester County, Maryland as ''Worcester County, MA''. The correct reference should be ''Worcester County, MD''.

*Final Action:* We are implementing the hospice wage index with a 1-year transition period as proposed, meaning the counties impacted will receive 50 percent of the rate from the current CBSA and 50 percent from the new OMB CBSA delineations for FY 2016 effective October 1, 2015.

2. Hospice Payment Update Percentage

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the market basket index, minus one 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 market basket percentage for that FY. The Act requires us to use the inpatient hospital market basket to determine the hospice payment rate update. In addition, section 3401(g) of the Affordable Care Act mandates that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''MFP adjustment''). A complete description of the MFP projection methodology is available on our Web site at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html*.

In addition to the MFP adjustment, section 3401(g) of the Affordable Care Act also mandates that in FY 2013 through FY 2019, the hospice payment update percentage will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act). The hospice payment update percentage for FY 2016 is based on the estimated inpatient hospital market basket update of 2.4 percent (based on IHS Global Insight, Inc.'s second quarter 2015 forecast with historical data through the first quarter of 2015). Due to the requirements at 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the estimated inpatient hospital market basket update for FY 2016 of 2.4 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.5 percentage point for FY 2016). The estimated inpatient hospital market basket update for FY 2016 is reduced further by a 0.3 percentage point, as mandated by the Affordable Care Act. In effect, the hospice payment update percentage for FY 2016 is 1.6 percent. If more recent data are subsequently available (for example, a more recent estimate of the inpatient hospital market basket update and MFP adjustment), we will use such data, if appropriate, to determine the FY 2016 market basket update and the MFP adjustment in the FY 2016 Hospice Rate Update final rule.

Currently, the labor portion of the hospice payment rates is as follows: For RHC, 68.71 percent; for CHC, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. Therefore, the non-labor portion of the payment rates is as follows: For RHC, 31.29 percent; for CHC, 31.29 percent; for General Inpatient Care, 35.99 percent; and for Respite Care, 45.87 percent.

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

*Comment:* Several commenters expressed appreciation for the positive payment update for FY 2016. However, the commenters believe that the update does not keep pace with the cost of providing highest quality care for beneficiaries. One commenter states that costs associated with workforce recruitment and training, supplies, and technology are all rising faster than reimbursement. The commenter further states that non-profit, mission-based hospices already operate on extremely slim margins: MedPAC calculated average non-profit hospice margins at

3.7 percent for 2012 with an expectation for margins to decline further (MedPAC March 2015). Some commenters note that margins for non-profit hospices are much lower than margins for for-profit hospices. The commenters strongly encourage CMS to reevaluate the payment update for FY 2016.

*Response:* The payment update to the hospice rates is based in statute as previously described in detail in this section and we do not have regulatory authority to alter the payment update.

*Final Action:* We are implementing the hospice payment update as discussed in the proposed rule.

3. FY 2016 Hospice Payment Rates

Historically, the hospice rate update has been published through a separate administrative instruction issued annually in the summer to provide adequate time to implement system change requirements; however, beginning in FY 2014 and for subsequent FY, we are using rulemaking as the means to update payment rates. This change was proposed in the FY 2014 Hospice Wage Index and Payment Rate Update proposed rule and finalized in the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48270). It is consistent with the rate update process in other Medicare benefits, and provides rate information to hospices as quickly as, or earlier than, when rates are published in an administrative instruction.

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

As discussed in section III.B, of this final rule, we will delay implementation of both the proposed RHC rates and the SIA payment until January 1, 2016. Between October 1, 2015 and December 31, 2015, hospices will continue to be paid a single RHC per diem payment amount. Effective January 1, 2016, the RHC rates for days 1 through 60 and days 61 and beyond would replace the single RHC per diem payment rate. As discussed in section III.B.3, we will make a SIA payment, in addition to the daily RHC payment, when direct patient care is provided by a RN or social worker during the last 7 days of the patient's life. The SIA payment will be 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. The SIA payment will also be adjusted by the appropriate wage index. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, for the SIA payment, the RHC rates will need to be adjusted by a budget neutrality factor. The budget neutrality adjustment that will apply to days 1 through 60 is equal to 1 minus the ratio of SIA payments for days 1 through 60 to the total payments for days 1 through 60 and is calculated to be 0.9806. The budget neutrality adjustment that will apply to days 61 and beyond is equal to 1 minus the ratio of SIA payments for days 61 and beyond to the total payments for days 61 and beyond and is calculated to be 0.9957. Lastly, the RHC rates will be increased by the FY 2016 hospice payment update percentage of 1.6 percent as discussed in section III.C.3. The FY 2016 RHC rate for hospice claims between October 1, 2015 and December 31, 2015 is shown in Table 20. The FY 2016 RHC rates for hospice claims for January 1, 2016 through September 30, 2016 are shown in Table 21. The FY 2016 payment rates for CHC, IRC, and GIP will be the FY 2015 payment rates increased by 1.6 percent. The rates for these three levels of care are shown in Table 22. The FY 2016 rates for hospices that do not submit the required quality data are shown in Tables 23, 24, and 25. The FY 2016 hospice payment rates will be effective for care and services furnished on or after October 1, 2015 through September 30, 2016.

TABLE 20—FY 2016 HOSPICE PAYMENT RATE FOR RHC FOR OCTOBER 1, 2015 THROUGH DECEMBER 31, 2015

| Code | Description | FY 2015 Payment rate | FY 2016 Hospice payment update percentage | FY 2016 Payment rate |
|---|---|---|---|---|
| 651 | Routine Home Care | $159.34 | × 1.016 | $161.89 |

TABLE 21—FY 2016 HOSPICE PAYMENT RATES FOR RHC FOR JANUARY 1, 2016 THROUGH SEPTEMBER 30, 2016

| Code | Description | Rates [1] | SIA Budget neutrality factor adjustment | FY 2016 Hospice payment update percentage | FY 2016 Payment rates |
|---|---|---|---|---|---|
| 651 | Routine Home Care (days 1–60) | $187.54 | × 0.9806 | × 1.016 | $186.84 |
| 651 | Routine Home Care (days 61+) | 145.14 | × 0.9957 | × 1.016 | 146.83 |

[1] See section III.B.2 for the RHC rates for days 1–60, and days 61 and beyond before accounting for the Service Intensity Add-on (SIA) payment budget neutrality factor and the FY 2016 hospice payment update percentage of 1.6 percent as required by section 1814(i)(1)(C) of the Act.

TABLE 22—FY 2016 HOSPICE PAYMENT RATES FOR CHC, IRC, AND GIP

| Code | Description | FY 2015 Payment rates | FY 2016 Hospice payment update percentage | FY 2016 Payment rate |
|---|---|---|---|---|
| 652 | Continuous Home Care Full Rate = 24 hours of care $ = 39.37 FY 2016 hourly rate | $929.91 | × 1.016 | $944.79 |
| 655 | Inpatient Respite Care | 164.81 | × 1.016 | 167.45 |
| 656 | General Inpatient Care | 708.77 | × 1.016 | 720.11 |

We reiterate in this final rule, that the Congress required in sections 1814(i)(5)(A) through (C) of the Act that hospices begin submitting quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index final rule (76 FR 47320 through 47324), we implemented a 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. We remind hospices that this applies to payments in FY 2016 (See Tables 23 through 25 below). For more information on the HQRP requirements please see section III.E in this final rule.

TABLE 23—FY 2016 HOSPICE PAYMENT RATE FOR RHC FOR OCTOBER 1, 2015 THROUGH DECEMBER 31, 2015 FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

| Code | Description | FY 2015 Payment rate | FY 2016 Hospice payment update of 1.6 percent minus 2 percentage points = −0.4 percent | FY 2016 Payment rate |
|---|---|---|---|---|
| 651 | Routine Home Care | $159.34 | × 0.996 | $158.70 |

TABLE 24—FY 2016 HOSPICE PAYMENT RATES FOR RHC FOR JANUARY 1, 2016 THROUGH SEPTEMBER 30, 2016 FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

| Code | Description | RHC Rates [1] | SIA Budget neutrality factor adjustment | FY 2016 Hospice payment update of 1.6 percent minus 2 percentage points = −0.4 percent | FY 2016 Payment rates |
|---|---|---|---|---|---|
| 651 | Routine Home Care (days 1–60) | $187.54 | × 0.9806 | × 0.996 | $183.17 |
| 651 | Routine Home Care (days 61+) | 145.14 | × 0.9957 | × 0.996 | 143.94 |

[1] See section III.B.2 for the RHC rates for days 1–60, and days 61 and beyond before accounting for the Service Intensity Add-on (SIA) payment budget neutrality factor and the FY 2016 hospice payment update percentage of 1.6 percent as required by section 1814(i)(1)(C) of the Act.

TABLE 25—FY 2016 HOSPICE PAYMENT RATES FOR CHC, IRC, AND GIP FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

| Code | Description | FY 2015 Payment rates | FY 2016 Hospice payment update of 1.6 percent minus 2 percentage points = −0.4 percent | FY 2016 Payment rate |
|---|---|---|---|---|
| 652 | Continuous Home Care Full Rate = 24 hours of care $ = 38.67 hourly rate. | $929.91 | × 0.996 | $926.19 |
| 655 | Inpatient Respite Care | 164.81 | × 0.996 | 164.15 |

TABLE 25—FY 2016 HOSPICE PAYMENT RATES FOR CHC, IRC, AND GIP FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA—Continued

| Code | Description | FY 2015 Payment rates | FY 2016 Hospice payment update of 1.6 percent minus 2 percentage points = −0.4 percent | FY 2016 Payment rate |
|---|---|---|---|---|
| 656 | General Inpatient Care | 708.77 | × 0.996 | 705.93 |

4. Hospice Aggregate Cap and the IMPACT Act of 2014

When the Medicare hospice benefit was implemented, the Congress included 2 limits on payments to hospices: An inpatient cap and an aggregate cap. As set out in sections 1861(dd)(2)(A)(iii) and 1814(i)(2)(A) through (C) of the Act, respectively, the hospice inpatient cap limits the total number of Medicare inpatient days (general inpatient care and respite care) to no more than 20 percent of a hospice's total Medicare hospice days. The intent of the inpatient cap was to ensure that hospice remained a home-based benefit. The hospice aggregate cap limits the total aggregate payment any individual hospice can receive in a year. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end of life.

The aggregate cap amount was set at $6,500 per beneficiary when first enacted in 1983; this was an amount hospice advocates agreed was well above the average cost of caring for a hospice patient.[50] Since 1983, the $6,500 amount has been adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI–U) from March 1984 to March of the cap year, as required by section 1814(i)(2)(B) of the Act. The cap amount is multiplied by the number of Medicare beneficiaries who received hospice care from a particular hospice during the year, resulting in its hospice aggregate cap, which is the allowable amount of total Medicare payments that hospice can receive for that cap year. The cap year is currently November 1 to October 31, and was set in place in the December 16, 1983 Hospice final rule (48 FR 56022).

[50] National Hospice and Palliative Care Organization (NHPCO), ''A Short History of the Medicare Hospice Cap on Total Expenditures.'' Web 19 Feb. 2014. *http://www.nhpco.org/sites/default/files/public/regulatory/History_of_Hospice_Cap.pdf.*

Section 1814(i)(2)(B)(i) and (ii) of the Act, as added by section 3(b) of the IMPACT Act requires, effective for the 2016 cap year (November 1, 2015 through October 31, 2016), that the cap amount for the previous year to be updated by the hospice payment update percentage, rather than the original $6,500 being annually adjusted by the change in the CPI–U for medical care expenditures since 1984. This new provision will sunset for cap years ending after September 30, 2025, at which time the annual update to the cap amount will revert back to the original methodology. This provision is estimated to result in $540 million in savings over 10 years starting in 2017.

As a result, we will update § 418.309 to reflect the new language added to section 1814(i)(2)(B) of the Act.

In accordance with section 1814(i)(2)(B)(i) of the Act, the hospice aggregate cap amount for the 2015 cap year, starting on November 1, 2014 and ending on October 31, 2015, will be $27,382.63. This amount was calculated by multiplying the original cap amount of $6,500 by the change in the CPI–U medical care expenditure category, from the fifth month of the 1984 accounting year (March 1984) to the fifth month the current accounting year (in this case, March 2015). The CPI–U for medical care expenditures for 1984 to present is available from the BLS Web site at: *http://www.bls.gov/cpi/home.htm.*

*Step 1:* From the BLS Web site given above, the March 2015 CPI–U for medical care expenditures is 444.020 and the 1984 CPI–U for medical care expenditures was 105.4.

*Step 2:* Divide the March 2015 CPI–U for medical care expenditures by the 1984 CPI–U for medical care expenditures to compute the change.
444.020/105.4 = 4.212713

*Step 3:* Multiply the original cap base amount ($6,500) by the result from step 2) to get the updated aggregate cap amount for the 2015 cap year.
$6,500 × 4.212713 = $27,382.63

As required by section 1814(i)(2)(B)(ii) of the Act, the hospice aggregate cap amount for the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016, will be the 2015 cap amount updated by the FY 2016 hospice payment update percentage (see section III.C.2 above). As such, the 2016 cap amount will be $27,820.75 ($27,382.63 * 1.016). A Change Request with the finalized hospice payment rates, a finalized hospice wage index, the Pricer for FY 2016, and the hospice cap amount for the cap year ending October 31, 2015 will be issued in the summer.

A summary of the comments we received regarding the aggregate cap and our responses to those comments appears below.

*Comment:* A number of commenters supported the use of payment update data to update the hospice aggregate cap. Some commenters suggested that CMS reduce the hospice aggregate cap between ten to fifteen percent and that a portion of the savings be utilized to support innovation and research around end-of-life, hospice, and palliative care. Another commenter stated that the aggregate cap should be adjusted to account for regional differences in payment. The commenter argued that providers in areas with an overall higher cost of living would hit the aggregate cap sooner than providers in areas with a lower cost of living and that the aggregate cap should be applied on a CBSA basis, not a national basis.

*Response:* We thank the commenters for their support. We reiterate that the use of hospice payment update percentage to update the hospice aggregate cap is mandated by the IMPACT Act. We also note that while we find the suggestion to adjust the hospice aggregate cap compelling, we would need statutory authority to reduce the hospice aggregate cap. In addition, we do not have statutory authority to change the aggregate cap amount by region or CBSA.

*Comment:* A commenter noted an error in our calculation of the aggregate cap amount for the 2015 cap year. In the proposed rule, (80 FR 25867), in Step 2,

we should have divided the March 2015 CPI–U for medical care expenditures, 444.020, by the 1984 CPI–U for medical care expenditures, 105.4. However, we inadvertently divided 440.020 by 105.4.

*Response:* We would like to thank the commenter for noticing the error and alerting us. We have corrected the error in the calculation in this final rule.

*D. Alignment of the Inpatient and Aggregate Cap Accounting Year With the Federal Fiscal Year*

As noted in section III.C.4, when the Medicare hospice benefit was implemented, the Congress included two limits on payments to hospices: An aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end-of-life. If a hospice's total Medicare payments for the cap year exceed such hospice's aggregate cap amount, then the hospice must repay the excess back to Medicare. The intent of the inpatient cap was to ensure that hospice remained a home-based benefit. If a hospice's inpatient days (GIP and respite) exceed 20 percent of all hospice days then, for inpatient care, the hospice is paid: (1) The sum of the total reimbursement for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to actual number of all inpatient days; and (2) the sum of the actual number of inpatient days in excess of the limitation by the routine home care rate.

1. Streamlined Method and Patient-by-Patient Proportional Method for Counting Beneficiaries To Determine Each Hospice's Aggregate Cap Amount

The aggregate cap amount for any given hospice is established by multiplying the cap amount by the number of Medicare beneficiaries who received hospice services during the year. Originally, the number of Medicare beneficiaries who received hospice services during the year was determined using a ''streamlined'' methodology whereby each beneficiary is counted as ''1'' in the initial cap year of the hospice election and is not counted in subsequent cap years. Specifically, the hospice includes in its number of Medicare beneficiaries those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap, and who have filed an election to receive hospice care in accordance with § 418.24 during the period beginning on September 28th (34 days before the beginning of the cap year) and ending on September 27th (35 days before the end of the cap year), using the best data available at the time of the calculation. This is applicable for cases in which a beneficiary received care from only one hospice. If a beneficiary received care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care with that hospice in that cap year, using the best data available at the time of the calculation. Using the streamlined method, a different timeframe from the cap year is used to count the number of Medicare beneficiaries because it allows those beneficiaries who elected hospice near the end of the cap year to be counted in the year when most of the services were provided (48 FR 38158).

During FY 2012 rulemaking, in addition to the streamlined method, CMS added a ''patient-by-patient proportional'' method as a way of calculating the number of Medicare beneficiaries who received hospice services during the year in determining the aggregate cap amount for any given hospice (76 FR 47309). This method specifies that a hospice should include in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. The total number of Medicare beneficiaries for a given hospice's cap year is determined by summing the whole or fractional share of each Medicare beneficiary that received hospice care during the cap year, from that hospice. Under the patient-by-patient proportional methodology, the timeframe for counting the number of Medicare beneficiaries is the same as the cap accounting year (November 1 through October 31). The aggregate cap amount for each hospice is now calculated using the patient-by-patient proportional method, except for those hospices that had their cap determination calculated under the streamlined method prior to the 2012 cap year, did not appeal the streamlined method used to determine the number of Medicare beneficiaries used in the aggregate cap calculation, and opted to continue to have their hospice aggregate cap calculated using the streamlined method no later than 60 days after receipt of its 2012 cap determination.

2. Inpatient and Aggregate Cap Accounting Year Timeframe

As stated in section III.C.4, the cap accounting year is currently November 1 to October 31. In the past, CMS has considered changing the cap accounting year to coincide with the hospice rate update year, which is the federal fiscal year (October 1 through September 30). In the FY 2011 Hospice Wage Index notice (75 FR 42951), CMS solicited comments on aligning the cap accounting year for both the inpatient and aggregate hospice cap to coincide with the FY. In the FY 2012 Hospice Wage Index proposed rule, we summarized the comments we received, stating that ''several commenters supported the idea of our aligning the cap year with the federal fiscal year; with some noting that the change would be appropriate for a multi-year apportioning approach (the patient-by-patient proportional method).'' Other commenters stated that we should not change the cap year at this time, and recommended that we wait for this to be accomplished as part of hospice payment reform (76 FR 26812).

In FY 2012, we decided not to finalize changing the cap accounting year to the FY, partly because of a concern that a large portion of providers could still be using the streamlined method. As stated earlier, the streamlined method has a different timeframe for counting the number of beneficiaries than the cap accounting year, allowing those beneficiaries who elected hospice near the end of the cap year to be counted in the year when most of the services were provided. However, for the 2013 cap year, only 486 hospices used the streamlined method to calculate the number of Medicare hospice patients and the remaining providers used the patient-by-patient proportional method. Since the majority of providers now use the patient-by-patient proportional method, we believe there is no longer an advantage to defining the cap accounting year differently from the hospice rate update year; maintaining a cap accounting year (as well as the period for counting beneficiaries under the streamlined method) that is different from the federal fiscal year creates an added layer of complexity that can lead to hospices unintentionally calculating their aggregate cap determinations incorrectly. In addition, shifting the cap accounting year timeframes to coincide with the hospice rate update year (the federal fiscal year) will better align with the intent of the new cap calculation methodology required by the IMPACT Act of 2014, as discussed in section III.C.4. Therefore, we are aligning the cap accounting year for both the inpatient cap and the hospice aggregate cap with the federal fiscal year for FYs 2017 and later. In addition to aligning the cap accounting year with the federal fiscal year, we will also align the

timeframe for counting the number of beneficiaries with the federal fiscal year. This will eliminate timeframe complexities associating with counting payments and beneficiaries differently from the federal fiscal year and will help hospices avoid mistakes in calculating their aggregate cap determinations.

In shifting the cap accounting year to match the federal fiscal year, we note that new section 1814(i)(2)(B)(ii) of the Act, as added by section 3(b) of the IMPACT Act, requires the cap amount for 2016 to be updated by the hospice payment update percentage in effect ''during the FY beginning on the October 1 preceding the beginning of the accounting year''. In other words, we interpret this to mean that the statute requires the 2016 cap amount to be updated using the most current hospice payment update percentage in effect at the start of that cap year. For the 2016 cap year, the 2015 cap amount will be updated by the FY 2016 hospice payment update percentage outlined in section III.C.2. For the 2017 cap year through the 2025 cap year, we will update the previous year's cap amount by the hospice payment update percentage for that current federal fiscal year. For the 2026 cap year and beyond, changing the cap accounting year to coincide with the federal fiscal year will require us to use the CPI–U for February when updating the cap amount, instead of the current process which uses the March CPI–U to update the cap amount. Section 1814(i)(2)(B) of the Act requires us to update the cap amount by the same percentage as the percentage increase or decrease in the medical care expenditure category of the CPI–U from March 1984 to the ''fifth month of the accounting year '' for all years except those accounting years that end after September 30, 2016 and before October 1, 2025.

In shifting the cap year to match the federal fiscal year, we are aligning the timeframes in which beneficiaries and payments are counted for the purposes of determining each individual hospice's aggregate cap amount (see table 26 below) as well as the timeframes in which days of hospice care are counted for the purposes determining whether a given hospice exceeded the inpatient cap. In the year of transition (2017 cap year), for the inpatient cap, we will calculate the percentage of all hospice days of care that were provided as inpatient days (GIP care and respite care) from November 1, 2016 through September 30, 2017 (11 months). For those hospices using the patient-by-patient proportional method for their aggregate cap determinations, for the 2017 cap year, we will count beneficiaries from November 1, 2016 to September 30, 2017. For those hospices using the streamlined method for their aggregate cap determinations, we will allow 3 extra days to count beneficiaries in the year of transition. Specifically, for the 2017 cap year (October 1, 2016 to September 30, 2017), we will count beneficiaries from September 28, 2016 to September 30, 2017, which is 12 months plus 3 days, in that cap year's calculation. For hospices using either the streamlined method or the patient-by-patient proportional method, we will count 11 months of payments from November 1, 2016 to September 30, 2017 for the 2017 cap year. For the 2018 cap year (October 1, 2017 to September 30, 2018), we will count both beneficiaries and payments for hospices using the streamlined or the patient-by-patient proportional methods from October 1, 2017 to September 30, 2018. Likewise, for the 2018 cap year, we will calculate the percentage of all hospice days of care that were provided as inpatient days (GIP care or respite care) from October 1, 2017 to September 30, 2018. Because of the non-discretionary language used by Congress in determining the cap for a year, the actual cap amount for the adjustment year will not be prorated for a shorter time frame. We solicited public comment on all aspects of the proposed alignment of the cap accounting year for both the inpatient cap and hospice aggregate cap, as well as the timeframe for counting the number of beneficiaries for the hospice aggregate cap, with the federal fiscal year, as articulated in this section, as well as the corresponding proposed changes to the regulations at § 418.308(c) in section VI.

TABLE 26—HOSPICE AGGREGATE CAP TIMEFRAMES FOR COUNTING BENEFICIARIES AND PAYMENTS FOR THE ALIGNMENT OF THE CAP ACCOUNTING YEAR WITH THE FEDERAL FISCAL YEAR

| Cap year | Beneficiaries | | Payments | |
|---|---|---|---|---|
| | Streamlined method | Patient-by-patient proportional method | Streamlined method | Patient-by-patient proportional method |
| 2016 | 9/28/15–9/27/16 | 11/1/15–10/31/16 | 11/1/15–10/31/16 | 11/1/15–10/31/16 |
| 2017 (Transition Year) | 9/28/16–9/30/17 | 11/1/16–9/30/17 | 11/1/16–9/30/17 | 11/1/16–9/30/17 |
| 2018 | 10/1/17– 9/30/18 | 10/1/17– 9/30/18 | 10/1/17– 9/30/18 | 10/1/17– 9/30/18 |

Summaries of the public comments and our responses to comments on all aspects of the proposed alignment of the cap accounting year with the federal fiscal year as well as the proposed changes to the regulations at § 418.308(c) are summarized below:

*Comment:* Commenters supported the proposed alignment of the inpatient and aggregate cap with the federal fiscal year, as well as the alignment of the timeframe for counting the number of beneficiaries with the federal fiscal year, and supported the proposed methodology for the transition year. Commenters encouraged CMS to issue, and direct the MACs to provide, timely notice of forthcoming changes and reminders to minimize confusion when hospice providers calculate and self-report their aggregate cap and to allow hospices to adequately track their cap status. Commenters wanted education and information on the transition and changes to the cap accounting year timeframe.

*Response:* We thank the commenters for their support and will finalize this policy as proposed. We note that the MACs currently send a reminder notice to hospices no later than 30 days prior to the due date of the self-determined cap. We encourage hospices to visit their respective MAC Web site regularly for announcements and updates regarding the hospice program. Please contact your MAC if you need information regarding the cap calculation or additional information.

*Comment:* Some commenters stated that the proposed rule eliminates the reference to March 31st in § 418.308 and requested that the final rule clarify that hospices are still required to file a self-determined inpatient and aggregate cap determination on or before March 31, 2017 for the 2016 cap year and on or before February 28, 2018 for the 2017

cap year. One commenter requested that CMS provide early notice on the due date for filing the aggregate cap determination each year since the removal of the reference to March 31st may be a source of confusion for hospice providers.

*Response:* We note that the regulatory text still states that the hospice must file its aggregate cap determination notice with its Medicare contractor no later than 5 months after the end of the cap year and remit any overpayment due at that time. Therefore, the regulatory text change continues to provide hospices with sufficient information to determine when aggregate cap self-determinations must be submitted to the MAC. Hospices are required to file a self-determined inpatient and aggregate cap determination on or before March 31, 2017 for the 2016 cap year and on or before February 28, 2018 for the 2017 cap year. We will finalize this policy as proposed, aligning the cap accounting year with the federal fiscal year and removing the reference to March 31st in § 418.308. The end of the cap accounting year for the 2017 cap year and future years will be the same as the end of the fiscal year. Therefore, it is clear that the clause in the regulation text ''5 months after the end of the cap year'' refers to the end of February for cap years 2017 and beyond.

*Final Action:* We are finalizing the proposal and proposed methodology to align the inpatient and aggregate cap accounting year, as well as the timeframe for counting the number of beneficiaries, with the federal fiscal year. We are also finalizing the proposed changes to § 418.308(c).

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

1. Background and Statutory Authority

Section 3004(c) of the Affordable Care Act amended section 1814(i)(5) of the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points could result in the annual market basket update being less than 0.0 percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the particular FY involved. Any such reduction would not be cumulative or be taken into account in computing the payment amount for subsequent FYs. Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form, manner, and at a time specified by the Secretary.

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

Any measures selected by the Secretary must be endorsed by the consensus-based entity, which holds a contract regarding performance measurement with the Secretary under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). However, section 1814(i)(5)(D)(ii) of the Act provides that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus-based entity, the Secretary may specify measures that are not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary. Our paramount concern is the successful development of a Hospice Quality Reporting Program (HQRP) that promotes the delivery of high quality healthcare services. We seek to adopt measures for the HQRP that promote patient-centered, high quality, and safe care. Our measure selection activities for the HQRP take into consideration input from the Measure Applications Partnership (MAP), convened by the NQF, as part of the established CMS pre-rulemaking process required under section 1890A of the Act. The MAP is a public-private partnership comprised of multi-stakeholder groups convened by the NQF for the primary purpose of providing input to CMS on the selection of certain categories of quality and efficiency measures, as required by section 1890A(a)(3) of the Act. By February 1st of each year, the NQF must provide that input to CMS. Input from the MAP is located at: (*http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx.* We also take into account national priorities, such as those established by the National Priorities Partnership at (*http://www.qualityforum.org/npp/*), the HHS Strategic Plan *http://www.hhs.gov/secretary/about/priorities/priorities.html*), the National Strategy for Quality Improvement in Healthcare, (*http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm*) and the CMS Quality Strategy (*http://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html*). To the extent practicable, we have sought to adopt measures endorsed by member organizations of the National Consensus Project recommended by multi-stakeholder organizations, and developed with the input of providers, purchasers/payers, and other stakeholders.

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

Beginning with the FY 2018 payment determination, for the purpose of streamlining the rulemaking process, we proposed that when we adopt measures for the HQRP beginning with a payment determination year, these measures are automatically adopted for all subsequent years' payment determinations, unless we propose to remove, suspend, or replace the measures.

Quality measures may be considered for removal by CMS if:

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

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

usual HQRP communication channels, including listening sessions, memos, email notification, and Web postings. In such instances, the removal of a measure will be formally announced in the next annual rulemaking cycle.

CMS did not propose to remove any measures for the FY 2017 reporting cycle. We invited public comment only on our proposal that once a quality measure is adopted, it be retained for use in the subsequent fiscal year payment determinations unless otherwise stated.

Public comments and our response to comments are summarized below. All comments received were supportive of the proposed policy that once a quality measure is adopted, it be retained for use in the subsequent fiscal year payment determinations until otherwise stated, as proposed.

*Comment:* CMS received several comments on our proposal that once a quality measure is adopted, it be retained for use in the subsequent fiscal year payment determinations until otherwise stated. All commenters were supportive of this proposal. Commenters appreciated the clarification from CMS and noted that the proposed reasons for removal of a measure are reasonable.

*Response:* CMS thanks commenters for their support of our proposal to retain measures that have been adopted for use in subsequent fiscal year payment determinations, unless otherwise stated.

*Comment:* Two commenters noted the effort required by hospices in reporting quality data, and stated that measures should be systematically reviewed on a regular basis to ensure they are able to distinguish performance among hospices, do not result in unintended consequences, and have demonstrated potential to improve care.

*Response:* CMS agrees with commenters that regularly assessing measures to ensure their value in distinguishing performance and improving care is vital to the success of the HQRP. For all measures implemented for use in the HQRP, CMS regularly conducts measure testing activities according to the blueprint for the CMS Measures Management System (*http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Measures ManagementSystemBlueprint.html*) to ensure that measures continue to demonstrate scientific acceptability (including reliability and validity) and meet the goals of the HQRP, which include distinguishing performance among hospices and contributing to better patient outcomes. If measure testing activities reveal that a measure meets one of the conditions for removal that is listed the proposed rule (measure performance among hospices high and unvarying, performance or improvement in a measure does not result in better patient outcomes, etc.), the measure will be considered for removal from the HQRP to avoid unintended consequences and ensure that providers' data collection efforts are meaningful and are contributing to quality of care.

*Comment:* Finally, one commenter noted that both current and new measures should be thoroughly evaluated and tested before removal from or introduction to the HQRP. This commenter recommended that measure data from the first two quarters after implementation not be used for measure evaluation, and that a minimum of 1 years' worth of measure data after implementation be used to evaluate measures. The commenter also noted that the measure evaluation process should include analysis to demonstrate not only the psychometric properties of measures, but also evidence of the measure's relationship to meaningful outcomes.

*Response:* CMS thanks the commenter for their recommendation, and agrees that testing the measure's relationship to meaningful patient and family outcomes is an important part of the measure development and testing process, especially for process measures. As part of the validity testing, specifically convergent validity testing, CMS examines the relationship between various measures (for example, process and outcome measures) to support measure development and demonstrate relationships between processes and outcomes of care.

*Final Action:* After consideration of the comments, we are finalizing our proposal that once a quality measure is adopted, it be retained for use in the subsequent fiscal year payment determinations until otherwise stated, as proposed.

4. Previously Adopted Quality Measures for FY 2016 and FY 2017 Payment Determination

As stated in the CY 2013 HH PPS final rule (77 FR 67068, 67133), CMS expanded the set of required measures to include additional measures endorsed by NQF. We also stated that to support the standardized collection and calculation of quality measures by CMS, collection of the needed data elements would require a standardized data collection instrument. In response, CMS developed and tested a hospice patient-level item set, the Hospice Item Set (HIS). Hospices are required to submit an HIS-Admission record and an HIS-Discharge record for each patient admission to hospice on or after July 1, 2014. In developing the standardized HIS, we considered comments offered in response to the CY 2013 HH PPS proposed rule (77 FR 41548, 41573). In the FY 2014 Hospice Wage Index final rule (78 FR 48257), and in compliance with section 1814(i)(5)(C) of the Act, we finalized the specific collection of data items that support the following six NQF endorsed measures and one modified measure for hospice:

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

To achieve a comprehensive set of hospice quality measures available for widespread use for quality improvement and informed decision making, and to carry out our commitment to develop a quality reporting program for hospices that uses standardized methods to collect data needed to calculate quality measures, we finalized the HIS effective July 1, 2014 (78 FR 48258). To meet the quality reporting requirements for hospices for the FY 2016 payment determination and each subsequent year, we require regular and ongoing electronic submission of the HIS data for each patient admission to hospice on or after July 1, 2014, regardless of payer or patient age (78 FR 48234, 48258). Collecting data on all patients provides CMS with the most robust, accurate reflection of the quality of care delivered to Medicare beneficiaries as compared with non-Medicare patients. Therefore, to measure the quality of care delivered to Medicare beneficiaries in the hospice setting, we collect quality data necessary to calculate the adopted measures on all patients. We finalized in the FY 2014 Hospice Wage Index (78 FR 48258) that hospice providers collect data on all patients in order to ensure that all patients regardless of payer or patient age are receiving the same care and that provider metrics measure performance across the spectrum of patients.

Hospices are required to complete and submit an HIS-Admission and an HIS-Discharge record for each patient admission. Hospices failing to report quality data via the HIS in FY 2015 will have their market basket update reduced by 2 percentage points in FY 2017 beginning in October 1, 2016. In the FY

2015 Hospice Wage Index final rule (79 FR 50485, 50487), we finalized the proposal to codify the HIS submission requirement at § 418.312. The System of Record (SOR) Notice titled ''Hospice Item Set (HIS) System,'' SOR number 09–70–0548, was published in the **Federal Register** on April 8, 2014 (79 FR 19341).

5. HQRP Quality Measures and Concepts Under Consideration for Future Years

We did not propose any new measures for FY 2017. However, we continue to work with our measure development and maintenance contractor to identify measure concepts for future implementation in the HQRP. In identifying priority areas for future measure enhancement and development, CMS takes into consideration input from numerous stakeholders, including the Measures Application Partnership (MAP), the Medicare Payment Advisory Commission (MedPAC), Technical Expert Panels, and national priorities, such as those established by the National Priorities Partnership, the HHS Strategic Plan, the National Strategy for Quality Improvement in Healthcare, and the CMS Quality Strategy. In addition, CMS takes into consideration vital feedback and input from research published by our payment reform contractor as well as from the Institute of Medicine (IOM) report, titled ''Dying in America'', released in September 2014.[51] Finally, the current HQRP measure set is also an important consideration for future measure development areas; future measure development areas should complement the current HQRP measure set, which includes HIS measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey measures. Based on input from stakeholders, CMS has identified several high priority concept areas for future measure development:

- Patient reported pain outcome measure that incorporates patient and/or proxy report regarding pain management;
- Claims-based measures focused on care practice patterns including skilled visits in the last days of life, burdensome transitions of care for patients in and out of the hospice benefit, and rates of live discharges from hospice;
- Responsiveness of hospice to patient and family care needs;
- Hospice team communication and care coordination

These measure concepts are under development, and details regarding measure definitions, data sources, data collection approaches, and timeline for implementation will be communicated in future rulemaking. CMS invited comments about these four high priority concept areas for future measure development.

Summaries of the public comments and our responses to comments regarding the four high priority concept areas for future measure development are provided below:

*Comment Summary:* Many comments were received about the HQRP quality measures and concepts under consideration for future years. Overall, commenters were supportive of CMS's efforts to develop a more robust quality reporting program that includes development of outcome measures, and additional measures that better capture hospice performance. One of the commenters, MedPAC, supported the development of the measure areas identified by CMS in the proposed rule, strongly encouraging CMS to pursue the development of these measures. Several commenters were supportive of CMS's approach to quality measure development in the HQRP, specifically, the use of Technical Expert Panels (TEP) and listening sessions to obtain expert and other stakeholder input. In regards to the pain outcome measure, a majority of commenters were supportive of this measure concept as pain outcomes remain an important indicator of quality end of life care. Several commenters noted the complexities associated with developing a pain outcome measure, including the fact that pain is a subjective value and that pain outcome measures should take into account patient preference for pain levels and treatment, not just reduction in pain intensity. A few commenters noted additional complexities in proxy reporting of patient's pain. One commenter cautioned CMS against a pain outcome measure that could bear the risk of contacting the patient or family for feedback ''at the wrong time''. With respect to claims-based measures, although several commenters were supportive of the claims-based measure concept areas identified in the proposed rule, the majority of commenters had concerns about using claims data as a source for quality measures. Commenters also had concerns about linking these claims-based measure concepts to quality of care. Several commenters noted that performance measures should guide and promote the quality of direct care received by hospice patients and families. Commenters expressed that performance measures should not be implemented in order to discourage or correct undesirable organizational practices. These commenters felt that utilization metrics should be linked to quality of care or patient/caregiver perception of quality of care. Several commenters were concerned that given CMS's criteria for measure retention, which include measure performance that relates to better patient outcomes and ensuring that measures do not lead to unintended consequences, claims-based utilization metrics may be at risk for elimination from the HQRP unless they are specifically linked to quality of care outcomes. To help establish such a link between utilization metrics and quality of care, one commenter suggested that CMS compare claims-based data to Hospice CAHPS® survey data to verify whether any claims-based utilization metrics are correlated with caregiver perception of quality of care. Several commenters also stated that, as a data source, hospice claims were insufficient sources of information for quality measure purposes. These commenters noted that claims do not have sufficient information to inform performance measures. For example, several commenters stated that hospice claims do not capture visits offered by chaplains, spiritual care professionals, or volunteers. These commenters felt these disciplines made important contributions to hospice care and their role and involvement should be captured on claims in any claims-based quality metric. With respect to the live discharges measure concept, a few commenters questioned how CMS would calculate the live discharge rate, noting that there are both legitimate and questionable reasons why a live discharge may occur, and that claims data could not distinguish between the two. Two commenters suggested CMS use the Program for Evaluating Payment Patterns Electronic Report (PEPPER) report definition of live discharge. In regards to the responsiveness and communication and care coordination measure concepts, commenters had mixed opinions on this measure area. A few commenters supported measure development in these areas, but other commenters had concerns about developing quality measures that address these aspects of care. A few commenters had concerns about the subjective nature of these areas of care. One commenter noted that there are few data points or metrics that CMS could utilize for comparative analysis of these aspects of care, and that CMS would

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

have to develop new definitions and benchmarks to capture data on these areas of care. Several commenters requested additional information on the measure areas identified by CMS in the rule. These commenters requested CMS provide more information on the proposed measure concept areas to allow for more thorough provider input. Additionally, a few commenters noted that several of the measure concepts under consideration by CMS are also captured, in some way, by the Hospice CAHPS® survey. Providers cautioned CMS against developing new measures that were duplicative of other HQRP requirements. Several commenters urged CMS to explore measure development in other areas not mentioned in the proposed rule. One commenter encouraged CMS to consider measure development for other psychosocial symptoms, such as anxiety and depression. Another commenter suggested CMS explore development measures around the provision of bereavement care and services, such as contacts made by hospices to the bereaved. This commenter also suggested that CMS consider measuring value as part of the HQRP; the commenter suggested such metrics as mean cost per diem and percent of dollars directly related to care and services for the patient/family. Another commenter requested that CMS consider the role that occupational therapists play in future measure development work. Finally, one commenter suggested that CMS take into consideration the American Academy of Hospice and Palliative Medicine (AAHPM) and Hospice and Palliative Nurses Association (HPNA), ''Measuring What Matters'' recommendations when considering future measure development areas. One commenter supported the development of a standardized patient assessment instrument that would include the collection for quality measure data. A few commenters reiterated the ACA requirements that any measures that are part of the HQRP must be: ''. . . endorsed by the consensus-based entity . . . . However . . . in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus-based entity, the Secretary may specify measures that are not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization . . .'' Commenters requested that CMS keep this statutory requirement in mind when developing and adopting measures for the HQRP. A few commenters asked that CMS be mindful of burden when considering new quality measures for adoption since quality data collection requires significant time and effort by providers. One commenter expressed concern about burden of data collection efforts, especially for small non-profit providers.

*Response:* CMS appreciates commenters' input and recommendations for future measure development areas for the HQRP. We plan to continue developing the HQRP to respond to the measure gaps identified by the Measures Application Partnership and others, and align measure development with the National Quality Strategy and the CMS Quality Strategy. We will take these comments into consideration in developing and implementing measures for future inclusion in the HQRP. CMS would like to take this opportunity to respond to commenters' concerns about the claims-based measure concepts outlined in the proposed rule, as well as commenters' concerns about using claims as a data source for quality performance measures. CMS appreciates commenters' concerns about linking any claims-based utilization or pattern of care measures with quality of care prior to implementation of any such measure in the HQRP. As noted by one commenter, developing and adopting measures that benefit patient outcomes and do not lead to negative unintended consequences is of the utmost importance to CMS. CMS convened a Technical Expert Panel (TEP) in May 2015 to inform the development of these measures under consideration, and linking these claims-based measure concepts to quality of care was an issue discussed by the TEP. Throughout the measure development process, CMS will conduct continued quantitative and qualitative analysis to determine correlation between these measure concepts and quality of care. CMS agrees that establishing a relationship between a measure concept and quality of care is a vital consideration in the measure development process. CMS submits all candidate measures for the HQRP for review by the Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF) and takes the MAP input into consideration in the measure development and implementation process. Per the requirements set forth in the ACA, CMS also re-iterates that our intent is to adopt measures that have been endorsed by NQF if at all possible. For more information on these measure concepts, CMS encourages readers to review the Measures Under Consideration (MUC) list and the MAP report, which are both published annually. More information on the MUC list and MAP report, as they relate to statutory requirements for pre-rulemaking can be found on the CMS Web site: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Quality Measures/Pre-Rule-Making.html*. Lastly, with respect to commenters' concerns about burden, CMS thanks the commenters for taking the time to express these views and suggestions. CMS attempts to reduce the regulatory burden of our quality reporting programs to the greatest extent possible. As required by the Paperwork Reduction Act (PRA) of 1995, any new data collection efforts or extensions of ongoing data collection efforts are submitted to the Office of Management and Budget (OMB) to ensure that federal agencies do not overburden the public with federally sponsored data collections.

6. 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 with respect to that FY.

b. Proposed Policy for New Facilities To Begin Submitting Quality Data

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50488) we finalized a policy stating that any hospice that receives its CCN notification letter on or after November 1 of the preceding year involved is excluded from any payment penalty for quality reporting purposes for the following FY. For example, if a hospice provider receives its CMS Certification Number (CCN) (also known as the Medicare Provider Number) notification letter on November 2, 2015 they would not be required to submit quality data for the current reporting period ending December 31, 2015 (which would affect the FY 2017 APU). In this instance, the hospice would begin with the next reporting period beginning January 1,

2016 and all subsequent years. However, if a hospice provider receives their CCN notification letter on October 31, 2015, they would be required to submit quality data for the current reporting period ending December 31, 2015 (which would affect the FY 2017 APU) and all subsequent years. This requirement was codified at § 418.312.

We proposed to modify our policies for the timing of new providers to begin reporting to CMS. Beginning with the FY 2018 payment determination and for each subsequent payment determination, we proposed that a new hospice be responsible for HQRP quality data reporting beginning on the date they receive their CCN notification letter from CMS. Under this proposal, hospices would be responsible for reporting quality data on patient admissions beginning on the date they receive their CCN notification.

Currently, new hospices may experience a lag between Medicare certification and receipt of their actual CCN Number. Since hospices cannot submit data to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system without a valid CCN Number, CMS proposed that new hospices begin collecting HIS quality data beginning on the date they receive their CCN notification letter by CMS. We believe this policy will provide sufficient time for new hospices to establish appropriate collection and reporting mechanisms to submit the required quality data to CMS. We invited public comment on this proposal that a new hospice be required to begin reporting quality data under HQRP beginning on the date they receive their CCN notification letter from CMS.

Summaries of the public comments and our responses to comments that a new hospice be required to begin reporting quality data under HQRP beginning on the date they receive their CCN notification from CMS are provided below:

*Comment:* CMS received several comments regarding the proposal for new hospices to begin reporting quality data under the HQRP beginning on the date they receive their CCN notification letter from CMS. The vast majority of commenters expressed support for this proposal since it provides a clear start date for HIS reporting, and allows sufficient time for hospices to establish processes for collection and submission of HIS data.

*Response:* CMS appreciates commenters support for this proposal.

*Comment:* Two commenters suggested alternative policies for new facilities to begin reporting quality data to CMS. One commenter recommended that the submission policy require facilities to collect data during the period leading up to Medicare certification and begin submitting their data as soon as they receive their CCN. Another commenter suggested that, to minimize the risk of penalties due to issues such as opening the CCN notification letter a day after it is received, the submission policy should require facilities to begin data collection at the start of the month following the CCN notification.

*Response:* In response to the commenter's suggestion to begin report data during the period leading up to Medicare certification and as soon as they receive their CCN, CMS would like to clarify the reasoning for our proposal for new providers to begin reporting HIS data on the date they receive their CCN notification letter. CMS proposed that providers begin reporting HIS data on the date they receive their CCN notification letter since hospices cannot register for the relevant QIES ASAP accounts needed to submit HIS data without a valid CCN. Thus, requiring quality data reporting beginning on the date the hospice receives their CCN notification letter aligns CMS policy for requirements for new providers with the functionality of the HIS data submission system (QIES ASAP). CMS would like to further clarify our proposal for new providers, including how our proposal in this year's proposed rule intersects with prior policies for new hospices. There are two considerations for providers to keep in mind with respect to HIS reporting; the first is when providers should begin reporting HIS data, the second is when providers will be subject to the potential two (2) percentage point APU reduction for failure to comply with HQRP requirements. CMS would like to clarify that, as stated in our proposal, providers are required to begin reporting data on the date that they receive their CCN notification letter. However, if the CCN notification letter were received on or after November 1st, they would not be subject to any financial penalty for failure to comply with HQRP requirements for the relevant reporting year. For example, if a provider receives their CCN notification letter on November 5th, 2015, that provider should begin submitting HIS data for patient admissions occurring on or after November 5th, 2015. However, since the hospice received their CCN notification letter after November 1st, they would not be evaluated for, or subject to any payment penalties for the relevant FY APU update (which in this instance is the FY 2017 APU, which is associated with patient admissions occurring 1/1/15–12/31/15). This proposed policy allows CMS to receive HIS data on all patient admissions on or after the date a hospice receives their CCN notification letter, while at the same time allowing hospices flexibility and time to establish the necessary accounts for data submission, before they are subject to the potential APU reduction for a given reporting year. Finally, to address the commenter's concern about providers being subject to payment penalties if they open the CCN notification letter the day after it is received, CMS believes our proposed policy grants providers ample time to establish the necessary accounts and operating systems for HIS data collection and submission, since there is often a significant lag time between the Medicare CCN application process and receipt of a provider's CCN Notification letter.

*Comment:* Finally, one commenter requested clarification on how the date the CCN notification letter was received would be verified by CMS.

*Response:* CMS would like to clarify that the ''date CCN notification letter is received'' would be the date listed in the letterhead of the CCN Notification Letter. This date is tracked by the Medicare Administrative Contractors (MACs) and is verifiable in MAC records.

*Final Action:* After consideration of the comments, we are finalizing our proposal that new providers be required to begin reporting quality data under for the HQRP beginning on the date they receive their CCN Notification Letter from CMS.

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

In the FY 2015 Hospice Wage Index final rule (79 FR 50486) we finalized our policy requiring that, for the FY 2017 reporting requirements, hospices must complete and submit HIS records for all patient admissions to hospice on or after July 1, 2014. Electronic submission is required for all HIS records. Although electronic submission of HIS records is required, hospices do not need to have an electronic medical record to complete or submit HIS data. In the FY 2014 Hospice Wage Index (78 FR 48258) we finalized that, to complete HIS records, providers can use either the Hospice Abstraction Reporting Tool (HART) software, which is free to download and use, or a vendor-designed software. HART provides an alternative option for hospice providers to collect

and maintain facility, patient, and HIS Record information for subsequent submission to the QIES ASAP system. Once HIS records are complete, electronic HIS files must be submitted to CMS via the QIES ASAP system. Electronic data submission via the QIES ASAP system is required for all HIS submissions; there are no other data submission methods available. Hospices have 30 days from a patient admission or discharge to submit the appropriate HIS record for that patient through the QIES ASAP system. CMS will continue to make HIS completion and submission software available to hospices at no cost. We provided details on data collection and submission timing at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html*.

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

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

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

The submission date for any given HIS record is defined as the date on which a provider submits the completed record. The submission date is the date on which the completed record is submitted and accepted by the QIES ASAP system. Beginning with the FY 2018 payment determination, we proposed that hospices must submit all HIS records within 30 days of the Event Date, which is the patient's admission date for HIS-Admission records or discharge date for HIS-Discharge records.

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

The QIES ASAP system validation edits are designed to monitor the timeliness and ensure that providers submitted records conform to the HIS data submission specifications. Providers are notified when timing criteria have not been met by warnings that appear on their Final Validation Reports. A standardized data collection approach that coincides with timely submission of data is essential in order to establish a robust quality reporting program and ensure the scientific reliability of the data received. We invited comments on the proposal that hospices must submit all HIS records within 30 days of the Event Date, which is the patient's admission date for HIS-Admission records or discharge date for HIS-Discharge records.

Summaries of the public comments and our responses to comments on the proposed data submission timelines and requirements for FY 2018 payment determination and subsequent years are provided below:

*Comment:* CMS received several comments regarding our proposal that hospices must submit all HIS records within 30 days of the Event Date. All commenters were supportive of this proposed submission timeline. One commenter agreed that timely submission of HIS data is necessary to facilitate CMS evaluation of HIS data and hospices' performance on quality measures.

*Response:* CMS appreciates commenters' support for our proposal that hospices must submit all HIS records within 30 days of the event date.

*Comment:* Another commenter addressed what they felt were inconsistencies between the CMS billing practices and some of the requirements for HIS reporting. The commenter also noted the burden created by these discrepancies for providers. This commenter urges CMS to consider minimizing differences across various CMS systems when developing new policies.

*Response:* CMS thanks the commenter for their concern regarding discrepancies between HIS reporting requirements and billing requirements. We believe that the provider is referring to HIS reporting requirements that are established and communicated to the provider community via sub-regulatory channels. This would include policies and guidelines regarding defining an ''admission'' and ''discharge'' for the purposes of HIS reporting, and reporting HIS data in the case of special circumstances, such as traveling patients. These policies and guidelines are released by CMS through sub-regulatory mechanisms, including the HIS Manual and HIS trainings. CMS would like to clarify that the process for updating sub-regulatory guidance is based on questions received through the Help Desk and feedback from the provider community received through other communication channels, such as ODFs and listening sessions. CMS takes these considerations into account when updating guidance in the HIS Manual, HIS trainings, and other documents such as FAQs and Fact Sheets.

*Comment:* Two commenters requested that CMS consider changing or removing the completion timelines for HIS records. One commenter noted that completion deadlines add to hospices' administrative burden for HIS data collection and do not facilitate compliance with submission deadline requirements.

*Response:* CMS appreciates commenters input on the value of the completion deadlines. Current sub-regulatory guidance produced by CMS (for example, HIS Manual, HIS trainings) state that the completion deadlines for HIS records are 14 days from the Event Date for HIS-Admission records and 7 days from the Event Date for HIS-Discharge records. Based on commenter input, CMS would like to clarify that the completion deadlines continue to reflect CMS guidance only; these guidelines are not statutorily specified and are not designated through regulation. These guidelines are intended to offer clear direction to hospice agencies in regards to the timely submission of HIS-Admission and HIS-Discharge records. The completion deadlines define only the latest possible date on which a hospice *should* complete each HIS record. This

guidance is meant to better align HIS completion processes with clinical workflow processes however, hospices may develop alternative internal policies to complete HIS records. Although it is at the discretion of the hospice to develop internal policies for completing HIS records, CMS continues to recommend that providers complete and attempt to submit HIS records early, prior to the proposed submission deadline of 30 days. Completing and attempting to submit records early allows providers ample time to address any technical issues encountered in the QIES ASAP submission process, such as correcting fatal error messages. Completing and attempting to submit records early will ensure that providers are able to comply with the proposed 30 day submission deadline. HQRP guidance documents, including the CMS HQRP Web site, HIS Manual, HIS trainings, Frequently Asked Questions (FAQs), and Fact Sheets continue to offer the most up-to-date CMS guidance to assist providers in the successful completion and submission of HIS records. Availability of updated guidance will be communicated to providers through the usual HQRP communication channels.

*Final Action:* After consideration of the comments, we are finalizing our proposal that hospices must submit all records within 30 days of the Event Date as proposed.

e. Proposed HQRP Data Submission and Compliance Thresholds for the FY 2018 Payment Determination and Subsequent Years

In order to accurately analyze quality reporting data received by hospice providers, it is imperative we receive ongoing and timely submission of all HIS-Admission and HIS-Discharge records. To date, the timeliness criteria for submission of HIS-Admission and HIS-Discharge records has never been proposed and finalized through rulemaking process. We believe this matter should be addressed by defining a clear standard for timeliness and compliance at this time. In response to input from our stakeholders seeking additional specificity related to HQRP compliance affecting FY payment determinations and, due to the importance of ensuring the integrity of quality data submitted to CMS, we proposed to set specific HQRP thresholds for timeliness of submission of hospice quality data beginning with data affecting the FY 2018 payment determination and subsequent years.

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

To summarize, we proposed to implement the timeliness threshold requirement beginning with all HIS admission and discharge records that occur on or after January 1, 2016, in accordance with the following schedule.

- Beginning on or after January 1, 2016 to December 31, 2016, hospices must submit at least 70 percent of all required HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2018.
- Beginning on or after January 1, 2017 to December 31, 2017, hospices must score at least 80 percent for all HIS records received within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2019.
- Beginning on or after January 1, 2018 to December 31, 2018, hospices must score at least 90 percent for all HIS records received within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2020.

We invited public comment on our proposal to implement the new data submission and compliance threshold requirement, as described previously, for the HQRP. Summaries of the public comments and our responses to comments are provided below:

*Comment:* CMS received many comments regarding the proposed establishment of data submission and compliance thresholds for FY2018 payment determinations and for subsequent years. All commenters but one were supportive of CMS's proposal. Commenters noted that the proposed thresholds seemed reasonable and achievable given current experience with HIS submission and agreed with the incremental nature of the threshold.

*Response:* CMS appreciates commenters' support of our proposed compliance thresholds. As stated in the proposed rule, we agree that timely submission of data is necessary to accurately analyze quality data received by providers. CMS is pleased that commenters find the proposed thresholds feasible given their current experience. To support feasibility of achieving these proposed compliance thresholds, CMS's measure development contractor conducted some preliminary analysis of Quarter 3 and Quarter 4 HIS data from 2014. According to preliminary analysis, the vast majority of hospices (92 percent) would have met the compliance thresholds at 70 percent. Moreover, 88 percent and 78 percent of hospices would have met the compliance thresholds at 80 percent and 90 percent, respectively. CMS believes this analysis is further evidence that these proposed compliance thresholds are reasonable and achievable by hospice providers.

*Comment:* One commenter recommended that CMS not implement the proposed timeliness criteria and data submission and compliance threshold until CMS develops appropriate reporting tools to allow hospice providers to determine their compliance statistics in CMS's system of records. This provider stated that, at the present time, CMS systems do now allow providers to monitor their performance with respect to timely submission of records. Another commenter supported CMS's proposal, but recommended a performance report be made available to hospices before the data submission and compliance thresholds are implemented.

*Response:* CMS agrees with commenters that having a reporting system that allows providers to monitor the timeliness of HIS record submission is important. However, CMS would like to clarify that the current reports available to providers in the CASPER system do allow providers to track the number of HIS records that are submitted within the 30 day submission timeframe. Currently, submitting an HIS record past the 30 day submission timeframe results in a non-fatal (warning) error. In April 2015, CMS made available three (3) new Hospice Reports in CASPER, which include

reports that can list HIS Record Errors by Field by Provider and HIS records with a specific error number. CMS will consider expanding this functionality in the future to tailor reporting functions to the exact data submission and compliance thresholds.

*Comment:* CMS received two comments related to the calculation of the compliance thresholds. One commenter appreciated that CMS is proposing an extension and exemptions process that would afford hospices an opportunity to request an extension or exemption from the 30 day submission timeframe for extenuating circumstances. Another commenter requested that CMS clarify the definition of a ''successful'' submission in the case of modification and inactivation requests.

*Response:* CMS appreciates commenters' requests for clarification. CMS would like to clarify the methodology that would be used for calculating the proposed 70 percent/80 percent/90 percent compliance thresholds. In general, CMS would include HIS records (HIS-Admission and HIS-Discharge) submitted for patient admissions and discharges occurring during the reporting period in the denominator of the compliance threshold calculation. The numerator of the compliance threshold calculation would include any records from the denominator that were submitted within the 30 day submission deadline. In response to commenters' concerns about extension and exemptions and modification and inactivation requests, CMS would like to clarify that the aforementioned methodology would be appropriately adjusted for cases where hospices were granted extensions/exemptions, and instances of modification/inactivation requests so that these instances did not ''count against'' providers in the proposed compliance threshold calculation.

*Comment:* Finally, CMS received one comment requesting CMS provide education about the proposed data submission and compliance thresholds.

*Response:* CMS appreciates the commenters' request for education and outreach about new requirements. CMS would like to reiterate that rulemaking is the official process through which new requirements are proposed, finalized, and communicated to the provider community. In addition, as further details of the data submission and compliance threshold are determined by CMS, we anticipate communicating these details through the regular HQRP communication channels, including Open Door Forums, webinars, listening sessions, memos, email notification, and web postings.

*Final Action:* After consideration of comments, and given the clarification above, CMS is finalizing our proposal to implement the new data submission and compliance thresholds for the FY 2018 payment determination and subsequent FY payment determinations.

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

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

In the event that a hospice seeks to request an exemptions or extension for quality reporting purposes, the hospice must request an exemption or extension within 30 days of the date that the extraordinary circumstances occurred by submitting the request to CMS via email to the HQRP mailbox at *HQRPReconsiderations@cms.hhs.gov*. Exception or extension requests sent to CMS through any other channel would not be considered as a valid request for an exception or extension from the HQRP's reporting requirements for any payment determination. In order to be considered, a request for an exemption or extension must contain all of the finalized requirements as outlined on our Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospiceQuality-Reporting/index.html*.

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

This process does not preclude us from granting extensions/exemptions to hospices that have not requested them when we determine that an extraordinary circumstance, such as an act of nature, affects an entire region or locale. We may grant an extension/exemption to a hospice if we determine that a systemic problem with our data collection systems directly affected the ability of the hospice to submit data. If we make the determination to grant an extension/exemption to hospices in a region or locale, we will communicate this decision through routine communication channels to hospices and vendors, including, but not limited to, Open Door Forums, ENews and notices on *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/*. We proposed to codify the HQRP Submission Exemption and Extension Requirements at § 418.312.

Summaries of public comments and our responses to comments on our proposal to codify the HQRP submission exemption and extension requirements are provided below:

*Comment:* CMS received several comments related to our previously finalized policy for extensions and exemptions. A few commenters had concerns about the process for requesting an extension or exemption, especially in the case of a widespread natural disaster. These commenters requested that CMS be able to accept requests for extensions and exemptions via means other than email. These commenters noted that in instances of certain widespread natural disasters, such as Hurricane Sandy or Hurricane Katrina, providers would not have been able to email CMS within 30 days of the event date. Commenters requested that CMS accept mail and verbal extension or exemption requests from providers, or that CMS extend the submission timeframe for requesting extensions or exemptions from 30 days to 90 days.

*Response:* CMS appreciates the commenters' concern about the process for requesting an extension or exemption in the circumstance of an extreme natural disaster. We refer readers to the extension and exemption policy that was finalized in the FY 2015 Hospice Wage Index and Payment Rate Update final rule. Additionally, we re-

iterate our policy that in case of an extraordinary circumstance, such as an act of natural disaster similar to Hurricanes Sandy and Katrina, CMS may grant extensions/exemptions to an entire region or locale without the need for providers to request an extension/exemption. As stated in our policy, if CMS makes a determination to grant an extension/exemption to an entire locale, we will communicate this decision through routine communication channels, such as through ODFs, email notification, and web postings.

*Comment:* CMS received two other comments about our previously finalized policy for extensions and exemptions. These two commenters requested that CMS consider revision of the criteria for granting an extension or exemptions to hospices that experience technological problems. These commenters noted that in some rare circumstances, a hospice may have collected and attempted to submit HIS data, but HIS record submissions were unsuccessful. One of the commenters also noted situations where an entire hospice's EHR is nonfunctional for a time due to issues with the vendor's cloud.

*Response:* CMS appreciates the commenters' concern about our policy for extensions and exemption in the case of technological difficulty. We refer readers to the extension and exemption policy that was finalized in the FY 2015 Hospice Wage Index and Payment Rate Update final rule. In addition, we would like to re-iterate the availability of other reporting and submission systems that are accessible to providers who may be experiencing technological difficulties. First, CMS would like to highlight the availability of final validation reports that are provided upon submission of records to the QIES ASAP system. These final validation reports indicate whether attempted HIS record submissions were successful. CMS highly recommends providers review the final validation report for all HIS submissions to ensure that attempted record submissions are successful. If providers are experiencing issues with record rejections and fatal errors, they can contact the appropriate Help Desk for assistance. Help Desk contact information can be found on the CMS HQRP Web site: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Help-Desks.html*. Second, CMS would like to re-iterate the availability of the HART software. The HART software is free software made available by CMS that all providers can use as an alternative to vendor-designed software to maintain facility, patient, and HIS record information for subsequent submission to QIES ASAP. All providers can download and use HART, and CMS recommends that all providers download HART so that the software is available to use as an alternative, should a provider experience issues with vendor-designed software. More information on HART can be found on the CMS HQRP Web site: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html*. Finally, CMS re-iterates our policy to grant an extension/exemptions to hospices that have not requested them in the case of systemic problems with CMS data collection systems that directly affect the ability of hospices to submit data.

*Final Action:* After consideration of comments, and given the clarification above, CMS is finalizing our proposal to codify the HQRP Submission Extension and Exemption Requirements at § 418.312.

8. Hospice CAHPS Participation Requirements for the 2018 APU and 2019 APU

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452), we stated that CMS would start national implementation of the CAHPS® Hospice Survey as of January 1, 2015. We started national implementation of this survey as planned. The CAHPS® Hospice Survey is a component of CMS' Hospice Quality Reporting Program that emphasizes the experiences of hospice patients and their primary caregivers listed in the hospice patients' records. Measures from the survey will be submitted to the National Quality Forum (NQF) for endorsement as hospice quality measures. We referred readers to our extensive discussion of the Hospice Experience of Care Survey in the Hospice Wage Index FY 2015 final rule for a description of the measurements involved and their relationship to the statutory requirement for hospice quality reporting (79 FR 50450 also refer to 78 FR 48261).

a. Background and Description of the Survey

The CAHPS® Hospice Survey is the first national hospice experience of care survey that includes standard survey administration protocols that allow for fair comparisons across hospices.

CMS developed the CAHPS® Hospice Survey with input from many stakeholders, including other government agencies, industry stakeholders, consumer groups and other key individuals and organizations involved in hospice care. The Survey was designed to measure and assess the experiences of hospice patients and their informal caregivers (family or friends). The goals of the survey are to:

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

The development process for the survey began in 2012 and included a public request for information about publicly available measures and important topics to measure (*78 FR 5458*); a review of the existing literature on tools that measure experiences with end-of-life care; exploratory interviews with caregivers of hospice patients; a technical expert panel attended by survey development and hospice care quality experts; cognitive interviews to test draft survey content; incorporation of public responses to **Federal Register** notices (*78 FR 48234*) and a field test conducted by CMS in November and December 2013.

The CAHPS® Hospice Survey treats the dying patient and his or her informal caregivers (family members or friends) as the unit of care. The Survey seeks information from the informal caregivers of patients who died while enrolled in hospices. Survey-eligible patients and caregivers are identified using hospice records. Fielding timelines give the respondent some recovery time (2 to 3 months), while simultaneously not delaying so long that the respondent is likely to forget details of the hospice experience. The survey focuses on topics that are important to hospice users and for which informal caregivers are the best source for gathering this information. Caregivers are presented with a set of standardized questions about their own experiences and the experiences of the patient in hospice care. During national implementation of this survey, hospices are required to conduct the survey to meet the Hospice Quality Reporting requirements, but individual caregivers will respond only if they voluntarily choose to do so. A survey Web site is the primary information resource for hospices and vendors (*www.hospicecahpssurvey.org*). The CAHPS® Hospice Survey is currently available in English, Spanish, Traditional Chinese, and Simplified Chinese. CMS will provide additional

translations of the survey over time in response to suggestions for any additional language translations. Requests for additional language translations should be made to the CMS Hospice CAHPS® Project Team at *hospicesurvey@cms.hhs.gov*.

In general, hospice patients and their caregivers are eligible for inclusion in the survey sample with the exception of the following ineligible groups: Patients who are under the age of 18 at the time of their death; patients who died fewer than 48 hours after last admission to hospice care; patients for whom no caregiver is listed or available, or for whom caregiver contact information is not known; patients whose primary caregiver is a legal guardian unlikely to be familiar with care experiences; patients for whom the primary caregiver has a foreign (Non-US or US Territory address) home address; decedents or caregivers of decedents who voluntarily requested that they not be contacted (those who sign ''no publicity'' requests while under the care of hospice or otherwise directly request not to be contacted). Patients whose last admission to hospice resulted in a live discharge will also be excluded. Identification of patients and caregivers for exclusion will be based on hospice administrative data. Additionally, caregivers under the age of 18 are excluded.

Hospices with fewer than 50 survey-eligible decedents/caregivers during the prior calendar year are exempt from the CAHPS® Hospice Survey data collection and reporting requirements for payment determination. Hospices with 50 to 699 survey-eligible decedents/caregivers in the prior year will be required to survey all cases. For hospices with 700 or more survey-eligible decedents/caregivers in the prior year, a sample of 700 will be drawn under an equal-probability design. Survey-eligible decedents/caregivers are defined as that group of decedent and caregiver pairs that meet all the criteria for inclusion in the survey sample.

We moved forward with a model of national survey implementation, which is similar to that of other CMS patient experience of care surveys. Medicare-certified hospices are required to contract with a third-party vendor that is CMS-trained and approved to administer the survey on their behalf. A list of approved vendors can be found at this Web site: *www.hospicecahpssurvey.org*. Hospices are required to contract with independent survey vendors to ensure that the data are unbiased and collected by an organization that is trained to collect this type of data. It is important that survey respondents feel comfortable sharing their experiences with an interviewer not directly involved in providing the care. We have successfully used this mode of data collection in other settings, including for Medicare-certified home health agencies. The goal is to ensure that we have comparable data across all hospices.

Consistent with many other CMS CAHPS® surveys that are publicly reported on CMS Web sites, CMS will publicly report hospice data when at least 12 months of data are available, so that valid comparisons can be made across hospice providers in the United States, to help patients, family and friends choose a hospice program for themselves or their loved ones.

b. Participation Requirements To Meet Quality Reporting Requirements for the FY 2018 APU

In section 3004(c) of the Affordable Care Act, the Secretary is directed to establish quality reporting requirements for Hospice Programs. The CAHPS® Hospice Survey is a component of the CMS Hospice Quality Reporting Requirements for the FY 2018 APU and subsequent years.

The CAHPS® Hospice Survey includes the measures detailed in Table 24. The individual survey questions that comprise each measure are listed under the measure. These measures are in the process of being submitted to the National Quality Forum (NQF).

TABLE 27—HOSPICE EXPERIENCE OF CARE SURVEY QUALITY MEASURES AND CONSTITUENT ITEMS

| Composite measures |
|---|
| Hospice team communication |
| • While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family member? |
| • While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand? |
| • How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care? |
| • While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition? |
| • While your family member was in hospice care, how often did the hospice team listen carefully to you? |
| Getting timely care |
| • While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it? |
| • How often did you get the help you needed from the hospice team during evenings, weekends, or holidays? |
| Treating family member with respect |
| • While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect? |
| • While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member? |
| Providing emotional support |
| • While your family member was in hospice care, how much emotional support did you get from the hospice team? |
| • In the weeks after your family member died, how much emotional support did you get from the hospice team? |
| Getting help for symptoms |
| • Did your family member get as much help with pain as he or she needed? |
| • How often did your family member get the help he or she needed for trouble breathing? |
| • How often did your family member get the help he or she needed for trouble with constipation? |
| • How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness? |
| Getting hospice care training |
| • Did the hospice team give you the training you needed about what side effects to watch for from pain medicine? |
| • Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member? |
| • Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing? |
| • Did the hospice team give you the training you needed about what to do if your family member became restless or agitated? |
| Single Item Measures |
| Providing support for religious and spiritual beliefs |

TABLE 27—HOSPICE EXPERIENCE OF CARE SURVEY QUALITY MEASURES AND CONSTITUENT ITEMS—Continued

| Composite measures |
|---|
| • (Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs.) While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team? |
| Information continuity |
| • While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member's condition or care? |
| Understanding the side effects of pain medication |
| • Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with you or your family member? |
| Global Measures |
| Overall rating of hospice |
| • Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care? |
| Recommend hospice |
| • Would you recommend this hospice to your friends and family? |

To comply with CMS's quality reporting requirements for the FY 2018 APU, hospices will be required to collect data using the CAHPS® Hospice Survey. Hospices would be able to comply by utilizing only CMS-approved third party vendors that are in compliance with the provisions at § 418.312(e). Ongoing monthly participation in the survey is required January 1, 2016 through December 31, 2016 for compliance with the FY 2018 APU.

Approved CAHPS® Hospice Survey vendors will submit data on the hospice's behalf to the CAHPS® Hospice Survey Data Center. The deadlines for data submission occur quarterly and are shown in Table 25 below. Deadlines are the second Wednesday of the submission months, which are August, November, February, and May. Deadlines are final; no late submissions will be accepted. However, in the event of extraordinary circumstances beyond the control of the provider, the provider will be able to request an exemption as previously noted in the Quality Measures for Hospice Quality Reporting Program and Data Submission Requirements for Payment Year FY 2016 and Beyond section. Hospice providers are responsible for making sure that their vendors are submitting Hospice CAHPS Survey data in a timely manner.

TABLE 28—CAHPS® HOSPICE SURVEY DATA SUBMISSION DATES FY2017 APU, FY2018 APU, AND FY2019 APU

| Sample months (that is, month of death) [1] | Quarterly data submission deadlines [2] |
|---|---|
| **FY2017 APU** | |
| Dry Run January–March 2015 (Q1) | August 12, 2015. |
| April–June 2015 (Q2) | November 11, 2015.[3] |
| July–September 2015 (Q3) | February 10, 2016. |
| October–December 2015 (Q4) | May 11, 2016. |
| **FY2018 APU** | |
| January–March 2016 (Q1) | August 10, 2016. |
| April–June 2016 (Q2) | November 9, 2016. |
| July–September 2016 (Q3) | February 8, 2017. |
| October–December 2016 (Q4) | May 10, 2017. |
| **FY2019 APU** | |
| January–March 2017 (Q1) | August 9, 2017. |
| April–June 2017 (Q2) | November 8, 2017. |
| July–September 2017 (Q3) | February, 14, 2018. |
| October–December 2017 (Q4) | May 9, 2018. |

[1] Data collection for each sample month initiates two 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 month.
[3] Correction Notice published 80 FR 24222.

In the FY 2014 Hospice Wage Index and Rate Update final rule, we stated that we would exempt very small hospices from CAHPS® Hospice Survey requirements. We propose to continue that exemption: Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2015 through December 31, 2015 are exempt from CAHPS® Hospice Survey data collection and reporting requirements for the 2018 APU. To qualify for the survey exemption for the FY 2018 APU, hospices must submit an exemption request form. This form will be available on the CAHPS® Hospice Survey Web site *http://www.hospicecahpssurvey.org*. Hospices are required to submit to CMS their total unique patient count for the period of January 1, 2015 through December 31, 2015. The

previously finalized due date for submitting the exemption request form for the FY 2018 APU is August 10, 2016 (79 FR 50493).

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

To meet participation requirements for the FY 2019 APU, we proposed that hospices collect data on an ongoing monthly basis from January 2017 through December 2017 (inclusive). Data submission deadlines for the 2019 APU will be announced in future rulemaking.

Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2016 through December 31, 2016 are exempt from CAHPS® Hospice Survey data collection and reporting requirements for the FY 2019 payment determination. To qualify, hospices must submit an exemption request form. This form will be available in first quarter 2017 on the CAHPS® Hospice Survey Web site *http://www.hospicecahpssurvey.org.*

Hospices are required to submit to CMS their total unique patient count for the period of January 1, 2016 through December 31, 2016. The due date for submitting the exemption request form for the FY 2018 APU is August 10, 2016 (Finalized 79 FR 50493).

d. Annual Payment Update

The Affordable Care Act requires that beginning with FY 2014 and each subsequent fiscal year, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that fiscal year, unless covered by specific exemptions. Any such reduction will not be cumulative and will not be taken into account in computing the payment amount for subsequent fiscal years. In the FY 2015 Hospice Wage Index, we added the CAHPS® Hospice Survey to the Hospice Quality Reporting Program requirements for the FY 2017 payment determination and determinations for subsequent years.

- To meet the HQRP requirements for the FY 2018 payment determination, hospices would collect survey data on a monthly basis for the months of January 1, 2016 through December 31, 2016 to qualify for the full APU.
- To meet the HQRP requirements for the FY 2019 payment determination, hospices would collect survey data on a monthly basis for the months of January 1, 2017 through December 31, 2017 to qualify for the full APU.

e. CAHPS® Hospice Survey Oversight Activities

We proposed to continue a requirement that vendors and hospice providers participate in CAHPS® Hospice Survey oversight activities to ensure compliance with Hospice CAHPS® technical specifications and survey requirements. The purpose of the oversight activities is to ensure that hospices and approved survey vendors follow the CAHPS® Hospice Survey technical specifications and thereby ensure the comparability of CAHPS® Hospice Survey data across hospices.

We proposed that the reconsiderations and appeals process for hospices failing to meet the Hospice CAHPS® data collection requirements would be part of the Reconsideration and Appeals process already developed for the Hospice Quality Reporting program. We encourage hospices interested in learning more about the CAHPS® Hospice Survey to visit the CAHPS® Hospice Survey Web site: *http://www.hospicecahpssurvey.org.*

*Comment:* A commenter encouraged CMS to compare scores on claims data to Hospice CAHPS® data to verify whether any of these are correlated with caregiver perception of quality care.

*Response:* CMS plans to do a variety of analyses after we have accumulated at least four quarters of Hospice CAHPS® data. We will consider conducting an analysis of the relationship of Hospice CAHPS® data to other types of scores.

*Comment:* A commenter supports the proposal related to the Hospice CAHPS® Survey oversight activities.

*Response:* CMS thanks the commenter for their support.

*Comment:* One commenter expressed the belief that the hospice CAHPS® survey was a mandate that placed an unfunded burden on hospices. The commenter requested that CMS consider including an administrative reimbursement mechanism in the final rule to help cover these costs.

*Response:* The Hospice CAHPS® survey follows the model that we implement for other quality reporting programs where CMS pays for the federal implementation of the program, the vendor training, monitoring, direct oversight with site visits, technical assistance to participating facilities, new facilities with signing up assistance, technical assistance to vendors, creation and maintenance of the official Web site with all survey materials, and the hospice facilities pay for vendor services. We have approved numerous Hospice CAHPS® vendors and we strongly recommend that hospices shop around and check out multiple vendors to find the vendor that best meets their needs and provides a good value to them.

*Comment:* A commenter asks that CMS clarify the role of the hospice facility in meeting performance standards for the Annual Payment Update. The commenter asked if hospices are responsible for making sure that their vendors are submitting data in a timely manner.

*Response:* In the FY 2015 Final Rule (79 FR 50493), CMS stated: ''Hospice providers are responsible for making sure that their vendors are submitting data in a timely manner. CMS intends that hospice providers are responsible for making sure that their vendors submit their Hospice CAHPS® Survey data in a timely manner and in compliance with the Hospice CAHPS® data submission deadlines. The CAHPS® Data Warehouse will provide hospices with data submission reports on the next business day after the submission. Hospices will receive email from the Warehouse each time a new report is placed in their warehouse folders letting them know that reports are available. However, we encourage hospices to work closely with their vendors to ensure their data is submitted in a timely manner. Please note that the survey vendors are acting on behalf of the hospice providers. This is the same policy for other CAHPS® surveys such as Hospital CAHPS® and Home Health CAHPS®.

*Comment:* A commenter reminded CMS of how challenging it is to capture patient-reported data from our patient population, which includes patients who are incapacitated or near death. They also reminded CMS of the importance of selecting future measures that matter to patients and reflect whole person needs, including social, cultural, and emotional dimensions.

*Response:* Currently CMS is not considering a patient experience of care survey where hospice patients are the respondents. CMS agrees that interviewing patients in the hospice setting is extraordinarily difficult, for both the interviewer and the patients. Some difficulties in surveying patients in this setting could include identifying those who are cognitively able to answer the survey questions and the patient's potential fear of retribution. It would therefore be more feasible to collect information from patients who are not close to death. A sample composed only of such patients is likely to reflect only a portion of the entire hospice experience. The CAHPS® Hospice Survey considers the patient and caregiver as a single unit of care. The

Survey interviews caregivers of patients who died while under hospice care. The interviews occur 2–3 months after the patient's death. This allows the caregiver to reflect upon and report upon the entire hospice experience.

*Final Action:* After consideration of comments, CMS is finalizing our proposal as proposed.

9. HQRP Reconsideration and Appeals Procedures for the FY 2016 Payment Determination and Subsequent Years

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

We clarified that any hospice that wishes to submit a reconsideration request must do so by submitting an email to CMS containing all of the requirements listed on the HQRP Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html*. Electronic email sent to *HQRPReconsiderations@cms.hhs.gov* is the only form of submission that will be accepted. Any reconsideration requests received through any other channel including U.S. postal service or phone will not be considered as a valid reconsideration request. We codified this process at § 418.312. In addition, we codified at § 418.306 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 and solicited comments on all of the proposals and the associated regulations text at § 418.312 and in § 418.306 in section VI.

In the past, only hospices found to be non-compliant with the reporting requirements set forth for a given payment determination received a notification of this finding along with instructions for requesting reconsideration in the form of a certified United States Postal Service (USPS) letter. In an effort to communicate as quickly, efficiently, and broadly as possible with hospices regarding annual compliance, we proposed additions to our communications method regarding annual notification of reporting compliance in the HQRP. In addition to sending a letter via regular USPS mail, beginning with the FY 2017 payment determination and for subsequent fiscal years, we proposed to use the QIES National System for Certification and Survey Provider Enhanced Reports (CASPER) Reporting as an additional mechanism to communicate to hospices regarding their compliance with the reporting requirements for the given reporting cycle. The electronic APU letters would be accessed using the CASPER Reporting Application. Requesting access to the CMS systems is performed in two steps. Details are provided on the QIES Technical Support Office Web site (direct link), *https://www.qtso.com/hospice.html*. Once successfully registered, access the CMS QIES to Success Welcome page *https://web.qiesnet.org/qiestosuccess/index.html* and select the ''CASPER Reporting'' link. Additional information about how to access the letters will be provided prior to the release of the letters.

We proposed to disseminate communications regarding the availability of hospice compliance reports in CASPER files through routine channels to hospices and vendors, including, but not limited to issuing memos, emails, Medicare Learning Network (MLN) announcements, and notices on *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html*.

We further proposed to publish a list of hospices who successfully meet the reporting requirements for the applicable payment determination on the HQRP Web site *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting.html*. We proposed updating the list after reconsideration requests are processed on an annual basis.

We invited comments on the proposals to add CASPER Reporting as an additional communication mechanism for the dissemination of compliance notifications and to publish a list of compliant hospices on the HQRP Web site. Public comments and our response to comments are summarized below.

*Comment:* CMS received three comments regarding our proposal to add CASPER Reporting as an additional communication mechanism for dissemination of compliance notifications. All commenters were supportive of this proposal. One commenter noted that adding CASPER as a communication mechanism will facilitate timely reconsideration requests, when appropriate.

*Response:* CMS appreciates commenters' support of our proposal to add CASPER reporting as an additional communication mechanism for disseminating notifications of compliance. CMS agrees that adding CASPER as an additional reporting mechanism would expedite communication with providers and facilitate the reconsideration process for providers who wish to request reconsideration.

*Comment:* CMS also received three comments on our proposal to publish a list of compliant hospices on the HQRP Web site. All commenters were supportive of this proposal; however, one commenter did request clarification from CMS on what information would be posted on the list of compliant providers. This commenter was also concerned that CMS was proposing to update the list after reconsideration requests were processed on an annual basis.

*Response:* CMS appreciates commenters' support of our proposal and commenters' requests for clarification. CMS anticipates that the proposed published list of compliant hospices on the HQRP Web site would include limited organizational data, such as the name and location of the hospice. With respect to the commenters' concern about updating the list of compliant hospices after the reconsideration period, CMS feels that finalizing the list of compliant providers for any given year is most appropriately done after the final determination of compliance is made. It is CMS's intent for the proposed published list of compliant hospices to be as complete and accurate as possible, giving recognition to all providers who were compliant with HQRP requirements for that year. Finalizing the list after requests for reconsideration are reviewed and a final determination of compliance is made allows for a more complete and accurate listing of compliant providers than developing any such list prior to reconsideration. Developing the list after the final determination of compliance has been made allows providers whose initial determination of noncompliance was reversed to be included in the list of compliant hospices for that year. Thus, CMS believes that finalizing the list of compliant hospices annually, after the reconsideration period will provide the

most accurate listing of hospices compliant with HQRP requirements.

*Final Action:* After consideration of comments, we are finalizing our proposal to add CASPER as an additional communication mechanism for disseminating notifications of noncompliance, as well as our proposal to publish a list of compliant hospices on the HQRP Web site.

10. 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. The procedures must ensure that a hospice would have the opportunity to review the data regarding the hospice's respective program before it is made public.

We recognize that public reporting of quality data is a vital component of a robust quality reporting program and are fully committed to developing the necessary systems for public reporting of hospice quality data. We also recognize that it is essential that the data made available to the public be meaningful and that comparing performance between hospices requires that measures be constructed from data collected in a standardized and uniform manner. Hospices have been required to use a standardized data collection approach (HIS) since July 1, 2014. Data from July 1, 2014 onward is currently being used to establish the scientific soundness of the quality measures prior to the onset of public reporting of the seven quality measures implemented in the HQRP. We believe it is critical to establish the reliability and validity of the quality measures prior to public reporting in order to demonstrate the ability of the quality measures to distinguish the quality of services provided. To establish reliability and validity of the quality measures, at least four quarters of data will be analyzed. Typically, the first one or two quarters of data reflect the learning curve of the facilities as they adopt standardized data collection procedures; these data often are not used to establish reliability and validity. We began data collection in CY 2014; the data from CY 2014 for Quarter 3 (Q3) will not be used for assessing validity and reliability of the quality measures. We are analyzing data collected by hospices during Quarter 4 (Q4) CY 2014 and Q1–Q3 CY 2015. Decisions about whether to report some or all of the quality measures publicly will be based on the findings of analysis of the CY 2015 data.

In addition, the Affordable Care Act requires that reporting be made public on a CMS Web site and that providers have an opportunity to review their data prior to public reporting. CMS will develop the infrastructure for public reporting, and provide hospices an opportunity to review their quality measure data prior to publicly reporting information about the quality of care provided by ''Medicare-certified'' hospice agencies throughout the nation. CMS also plans to make available provider-level feedback reports in the CASPER system. These provider-level feedback reports or ''quality reports'' will be separate from public reporting and will be for provider viewing only, for the purposes of internal provider quality improvement. As is common in other quality reporting programs, quality reports would contain feedback on facility-level performance on quality metrics, as well as benchmarks and thresholds. For the CY 2014 Reporting Cycle, there were no quality reports available in CASPER; however, CMS anticipates that provider-level quality reports will begin to be available sometime in CY 2015. CMS anticipates that providers would use the quality reports as part of their Quality Assessment and Performance Improvement (QAPI) efforts.

As part of our ongoing efforts to make healthcare more transparent, affordable, and accountable, the HQRP is prepared to post hospice data on a public data set, the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File located at *https://data.cms.hhs.gov*. This site includes information on services and procedures provided to Medicare beneficiaries by physicians and other healthcare professionals and serves as a helpful resource to the healthcare community. A timeline for posting hospice data on a public data set has not been determined by CMS. Should a timeline become available prior to the next annual rulemaking cycle, details would be announced via regular HQRP communication channels, including listening sessions, memos, email notification, and Web postings.

Furthermore, to meet the requirement for making such data public, we will develop a CMS Compare Web site for hospice, which will list hospice providers geographically. Consumers can search for all Medicare approved hospice providers that serve their city or zip code (which would include the quality measures and CAHPS® Hospice Survey results) and then find the agencies offering the types of services they need. Like other CMS Compare Web sites, the Hospice Compare Web site will feature a quality rating system that gives each hospice a rating of between one (1) and five (5) stars. Hospices will have prepublication access to their own agency's quality data, which enables each agency to know how it is performing before public posting of data on the Compare Web site. Decisions regarding how the rating system will determine a providers star rating and methods used for calculations, as well as a proposed timeline for implementation will be announced via regular HQRP communication channels, including listening sessions, memos, email notification, provider association calls, Open Door Forums, and Web postings. We will announce the timeline for public reporting of quality measure data in future rulemaking.

Summaries of public comments and our responses to comments regarding the public display of quality measures and other hospice data for the HQRP are provided below:

*Comment:* CMS received several comments that were generally supportive of public reporting of quality measure data. Commenters noted that they were in favor of CMS's continued efforts to assess quality and have transparent reporting of results. Commenters were also in favor of the availability of provider-level quality reports in CASPER, noting that the availability of such reports is a way for hospices to engage in benchmarking to inform their QAPI efforts. Commenters supported CMS's movement towards quality benchmarking and public reporting since it supports a hospice's ability to identify and resolve performance gaps while increasing transparency and accountability in the health care sector. While no commenters were unsupportive of public reporting or provider-level feedback reports in general, several commenters did have suggestions, recommendations, and concerns about specific aspects of public availability of data.

*Response:* CMS appreciates commenters' support of public reporting of quality measure data and the availability of provider-level feedback reports in CASPER. We address commenters' specific concerns with respect to public reporting and provider-level quality reports below.

*Comment:* CMS received a few comments about the timing for public reporting of quality data. One commenter noted that although continued measure development for new measures is important, measure development should not slow efforts to provide timely feedback to hospices on existing measures and public reporting of any existing measures. Another

commenter had concerns about the unintended consequences of releasing data too hastily. This commenter suggested that public reporting of hospice performance data occur gradually and carefully to ensure the data is accurate and presented in a format that is meaningful and actionable for both patients and physicians. The commenter appreciated CMS's efforts to evaluate at least four quarters of data to establish reliability and validity of the quality measures prior to public reporting. However, the commenter noted their opinion that four quarters worth of data is an insufficient foundation on which to draw conclusions about the accuracy of these measures, especially given the newness of these reporting requirements. Another commenter supported CMS's plan to analyze four (4) quarters worth of data to establish reliability and validity of quality measures and ensure accuracy of data before public reporting begins.

*Response:* CMS appreciates commenters' concerns about the timeline for public reporting of quality data. CMS agrees with the one commenter's sentiment that, while important, development of quality measures for future use in the HQRP should not delay public reporting or provider-level feedback reports. CMS is committed to ensuring the availability of public and provider-level data as soon as feasible, while ensuring that data is analyzed for scientific soundness and appropriateness for public reporting. CMS understands the unintended consequences of making data available to the public before comprehensive analyses have been conducted. CMS assures commenters that establishing the scientific soundness of data is of the utmost importance. In response to the commenter's concern about whether four (4) quarters of data is sufficient to establish reliability and validity of quality measures, we agree with the commenter that having sufficient evidence to support the reliability and validity of the measures is important prior to public reporting. We also agree that the data collected during the initial phase of the required reporting may reflect hospices' learning curve. To take this into account, as stated in the proposed rule, the reliability and validity testing will not use the data collected during the first reporting quarter (Q3, 2014). As stated in the proposed rule, CMS will use the four subsequent quarters of data (Q4 2014 and Q1–Q3 2015) for testing. Only measures that show sufficient reliability and validity will be identified as appropriate for public reporting. Furthermore, reliability and validity testing will be ongoing for all measures implemented in the HQRP as more quarters of data become available.

*Comment:* Another commenter recommended that CMS delay public reporting until results from measures derived from the HIS and the CAHPS® hospice survey is available. This commenter felt that although the concept of hospice has fairly wide public recognition, knowledge about hospice practice is minimal among the public. The commenter noted that the public may not be familiar with the processes behind the measures derived from HIS data, nor might the public be able to understand the relationship of those processes to quality of care. Additionally, the commenter noted that the HIS measures are limited in scope and, presented alone, HIS data might fall short of presenting a comprehensive picture of hospice services. The commenter recommended that CMS delay public posting of data until analysis of HIS and CAHPS® data has been completed.

*Response:* CMS appreciates the commenter's feedback on public reporting of HIS and CAHPS® data. CMS plans to use an approach for public reporting of these two data sources that mirrors approaches used in public reporting of quality data in other quality reporting programs, such as what is currently publicly displayed on Nursing Home Compare, Physician Compare, the Medicare Advantage Plan Finder, Dialysis Facility Compare, and Home Health Compare.

*Comment:* Two commenters suggested that CMS take steps to understand and develop the form, manner, and context in which data would be presented to the public. One commenter urged CMS that prior to sharing these data with the public, CMS should take time to carefully analyze quality data to better understand what types, and formats of data are most valuable to patients and providers. Another commenter requested that CMS develop educational material that explains hospice practice to aid in interpretation of publicly reported data.

*Response:* CMS agrees that any publicly reported data should be presented in a manner that is meaningful and understandable by the general public. CMS will take steps to ensure that any publicly reported data is displayed in an appropriate and meaningful manner. CMS will again mirror approaches used in other quality reporting programs and will solicit input from key stakeholders and technical experts in the development of the presentation of publicly available data, which includes a transparent process that will contain multiple opportunities for stakeholder input.

*Comment:* One commenter requested clarification from CMS about the process for providers to review quality measure data prior to public reporting, specifically, what the purpose of this process was.

*Response:* As stated in the proposed rule, CMS will develop the infrastructure for public reporting and method for hospices to preview their quality data prior to publicly reporting any such information. Exact details and reports will be forthcoming in future rules.

*Comment:* CMS received several comments regarding the availability of provider-level quality reports in CASPER. As noted above, commenters were supportive of the availability of these reports, though a few commenters did have suggestions for CMS regarding quality reports. CMS received three comments about the timing of quality reports in CASPER. One commenter stated that CMS did not plan to make quality reports available in CASPER until 2020 or later. Another commenter requested that CMS provide non-public quarterly performance reports to hospices that include benchmarking data for at least one year before publishing the results publicly on a compare Web site. The commenter stated that this one year period would give hospices the chance to make improvements in their performance before data is publicly reported. Another commenter urged CMS to provide feedback reports as frequently as possible and on a timely basis so that hospices have sufficient opportunity to learn from the data and make adjustments to practice before incurring penalties. This commenter also encouraged CMS to ensure that the data in these reports is presented in a user-friendly and actionable format.

*Response:* CMS thanks commenters for their feedback on the availability of provider-level quality reports in CASPER. First, we would like to clarify our timeline for the availability of quality reports. CMS agrees that providing feedback to hospice providers as soon as is feasible is a critical step in the process of quality improvement, since providers need data about their performance to inform QAPI and other performance improvement efforts. As stated in the proposed rule, CMS anticipates that quality reports will be available sometime in calendar year 2015; thus, we respectfully correct the commenter's misunderstanding that

provider-level quality reports would not be available until 2020. Given our anticipated timeline for the release of provider-level quality reports in 2015 and our timeline for public reporting, which we have stated in prior rules may occur in 2017, hospice providers would have all of 2016 to review their quality reports in CASPER and continue to develop performance improvement projects to improve quality measure scores prior to public reporting. We would also like to clarify that the intent of the provider-level feedback reports in CASPER would provide hospices with the ''benchmarking'' data mentioned by one commenter since, as stated in the proposed rule, the purpose of quality reports is to provide feedback on facility-level performance on quality metrics, including benchmarks and thresholds. CMS appreciates the commenter's request to make quality reports available quarterly; CMS will take this suggested quarterly timeframe under consideration as we consider how often quality data should be ''refreshed'' in CASPER quality reports. Finally, CMS agrees with the commenter that quality reports should provide user-friendly, actionable information. CMS will ensure that provider-level quality reports are meaningful and provide actionable information for providers to improve their care.

*Comment:* Though commenters were generally supportive of public reporting of quality data, several commenters expressed concerns over the methodology for the 5-star rating that CMS proposes to use as part of the Hospice Compare Web site. Two commenters were concerned about the development of a 5-star methodology where the majority of providers would be placed in the ''average'' star range. These commenters were concerned about the consumer perception of an ''average'' rating and encouraged CMS to develop a 5-star rating system that allows all hospices to aim for and achieve a 5-star rating. Commenters also encouraged CMS to involve providers and stakeholders in the development of the methodology for the 5-star rating system. Commenters also encouraged CMS to ensure any 5-star methodology is based on accurate data and evidence-based methodologies, and to allow ample opportunity for feedback on any proposed methodology. Commenters encouraged CMS to carefully consider the structure and presentation of a the 5-star rating system, including a consumer-friendly explanation of quality measures so that the public can easily interpret the data and use it for meaningful health care decision-making. Finally, one commenter cautioned CMS to ensure the accuracy of information, including basic demographic data such as addresses and practice affiliations, in any Compare databases prior to their launch.

*Response:* CMS appreciates commenters' input on the development of a Hospice Compare Web site and 5-star rating system for hospices. CMS would like to assure commenters that it is of paramount concern to develop a 5-star methodology that is tested and evidence-based, and can meaningfully distinguish between quality of care offered by providers. CMS agrees that presenting any 5-star rating in a manner that is meaningful and consumer-friendly is important, and CMS will ensure that publicly available data is displayed in a manner that is useful to the public. As with the development of 5-star methodology in other quality reporting programs, CMS will allow continued opportunities for the provider community and other stakeholders to comment on and provide input to the proposed rating system. In addition to regular HQRP communication channels, CMS will solicit input from the public regarding 5-star methodology through special listening sessions, invitation to submit comments via a Help Desk mailbox, Open Door Forums, and other opportunities.

*F. Clarification Regarding Diagnosis Reporting on Hospice Claims*

To ensure hospices are aware of the issues and requirements when providing compassionate end-of-life care to Medicare beneficiaries, we provided extensive background regarding program vulnerabilities; hospice eligibility requirements; and the hospice assessment of conditions and comorbidities required by regulation in the proposed rule (80 FR 25877—25880). The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD–10–CM) Coding Guidelines state the following regarding the selection of the principal diagnosis: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. In the case of selection of a principal diagnosis for hospice care, this would mean the diagnosis most contributory to the terminal prognosis of the individual. In the instance where two or more diagnoses equally meet the criteria for principal diagnosis, ICD–10–CM coding guidelines do not provide sequencing direction, and thus, any one of the diagnoses may be sequenced first, meaning to report all of those diagnoses meeting the criteria as a principal diagnosis. Per ICD–10–CM Coding Guidelines, for diagnosis reporting purposes, the definition for ''other diagnoses'' is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. ICD–10–CM coding guidelines are clear that all diagnoses affecting the management and treatment of the individual within the healthcare setting are requirement to be reported. This has been longstanding existing policy. Adherence to coding guidelines when assigning ICD–9–CM diagnosis and procedure codes through September 30, 2015 or ICD–10–CM diagnosis and procedure codes on and after October 1, 2015 is required under HHS regulations at 45 CFR 162.1002(b) and (c), respectively, as well as our regulations at 45 CFR 162.1002.

However, though established coding guidelines are required, it does not appear that all hospices are coding per coding guidelines on hospice claims. In 2010, over 77 percent of hospice claims reported only one diagnosis. Previous rules have discussed requirements for hospice diagnosis reporting on claims and the importance of complete and accurate coding. Preliminary analysis of FY 2014 claims data demonstrates that hospice diagnosis coding is improving; however, challenges remain. Analysis of FY 2014 claims data indicates that 49 percent of hospice claims listed only one diagnosis.[52] We conducted additional analysis on instances where only one diagnosis was reported on the FY 2014 hospice claim and found that 50 percent of these beneficiaries had, on average, eight or more chronic conditions and 75 percent had, on average, five or more chronic conditions.[53] These chronic, comorbid conditions include: hypertension, anemia, congestive heart failure, chronic obstructive pulmonary disease, ischemic heart disease, depression,

[52] Preliminary FY 2014 hospice claims data from the Chronic Conditions Data Warehouse (CCW), accessed on January 13, 2015.

[53] Preliminary FY 2014 hospice claims data from the Chronic Conditions Data Warehouse (CCW), accessed on January 21, 2015.

diabetes and atrial fibrillation, to name a few.

In the Medicare Program; Hospice Wage Index for Fiscal Year 2013 Notice (77 FR 44248) we stated that hospices should report, on hospice claims, all coexisting or additional diagnoses that are related to the terminal illness; they should not report coexisting or additional diagnoses that are unrelated to the terminal illness, even though coding guidelines required the reporting of all diagnoses that affect patient assessment and planning. However, as discussed earlier in this section, there is widely varying interpretation as to what factors influence the terminal prognosis of the individual (that is, what conditions render the individual terminally ill and which conditions are related). Furthermore, based on the numerous comments received in previous rulemaking, and anecdotal reports from hospices, hospice beneficiaries, and non-hospice providers discussed above, we are concerned that hospices may not be conducting a comprehensive assessment nor updating the plan of care as articulated by the CoPs to recognize the conditions that affect an individual's terminal prognosis.

Therefore, we are clarifying 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. This is in keeping with the requirements of determining whether an individual is terminally ill. This will also include the reporting of any mental health disorders and conditions that would affect the plan of care as hospices are to assess and provide care for identified psychosocial and emotional needs, as well as, for the physical and spiritual needs. Our regulations at § 418.25(b) state, ''in reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

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

ICD–10–CM Coding Guidelines state that diagnoses should be reported that develop subsequently, coexist, or affect the treatment of the individual. Furthermore, having these diagnoses reported on claims falls under the authority of the Affordable Care Act for the collection of data to inform hospice payment reform. Section 3132 a(1)(C) of the Affordable Care Act states that the Secretary may collect the additional data and information on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

We did not propose any new regulations nor solicit comments with this coding clarification as these clarifications are based on existing ICD–9–CM and ICD–10–CM coding guidelines, but received several comments.

Most commenters asked whether hospices would have to identify diagnoses as related or unrelated on hospice claims and if there would be a modifier created for that identification. Some commenters stated it would be burdensome to identify and report all diagnoses, while others expressed concern that this would mean that hospices would be financially responsible for all reported diagnoses. Some commenters asked what the purpose is for collecting this information and felt that there is no value added by collecting all diagnoses. Several commenters stated that CMS should provide further clarification as to the scope of diagnoses hospices are expected to cover and more clear criteria as to what are unrelated conditions. One industry commenter felt that CMS should define ''terminal illness'' and ''related conditions'' to provide more clear criteria for the expectation as to what hospices are required to cover. One commenter stated the CMS has changed its interpretation of the hospice regulations and that this is a requirement without a purpose. Several commenters felt that the phrase ''virtually all'' is a very ambiguous standard and CMS should provide greater clarity as to its meaning. And, as in previous years' rules, some commenters provided specific clinical scenarios as to why a condition was related or unrelated.

We appreciate the varying interpretations of what hospices' view as holistic and comprehensive end of life care. However, as articulated in section II of this rule, since the implementation of the Medicare hospice benefit in 1983, we have stated that it is our general view that hospices are required to provide virtually all the care that is needed by terminally ill individuals and we would expect to see little being provided outside of the benefit. Admission to hospice must be based on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any). Therefore, we expect that the hospice medical director follow the requirements articulated at 42 CFR 418.25. In a separate section at 42 CFR 418.54(c), hospice's are expected to uphold the responsibilities articulated in regulations regarding the requirements of the initial and comprehensive assessments which becomes part of the patient's hospice medical record and should not require an extensive historical review of previous healthcare records. Modifiers for the hospice claim form are not necessary at this time to identify related or unrelated conditions.

The American Health Information Management Association (AHIMA) provides procedure instructions for diagnosis reporting using coding guidance for coding certification.[54] These coding procedures are used for determining which diagnoses to report for those in the inpatient setting. Hospices follow coding guidelines for the inpatient setting. The guidelines state to sequence those diagnoses that are listed in the medical record with the principal diagnosis listed first. Additionally, these guidelines state to code other diagnoses that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. These represent additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring. These additional diagnoses include those that require active intervention during hospitalization and those that require active management of chronic disease during hospitalization, which is defined as a patient who is continued on chronic management at time of hospitalization. These coding guidelines instruct to code diagnoses of chronic systemic or generalized conditions that are not under active management when a physician documents them in the record and that may have a bearing on the management of the patient. Specifically, all diagnoses affecting the plan of care for the individual, which is in line with the hospice coverage requirements which state that hospices are to provide services for the palliation and management of the terminal illness and related conditions, are to be reported on the hospice claim.

The purpose of collecting this data, which is required in every other healthcare setting as per coding guidelines, is to have adequate data on hospice patient characteristics. This data will help to inform thoughtful,

[54] *http://www.ahima.org/~/media/AHIMA/Files/Certification/CCS%20Coding%20Instructions.ashx?la=en.*

appropriate, and clinically relevant policy for future rulemaking. In order to consider any future refinements, such as a case mix system which utilizes diagnosis information as a few commenters suggested, it is imperative that detailed patient characteristics are available to determine whether a case mix payment system could be achieved. One industry association felt that we should consider a risk-adjusted payment system based on patient characteristics including comorbidities, which would also require more detailed information regarding the patient.

## IV. Collection of Information Requirements

This document does not impose additional information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. All information collection discussed in this final rule have been approved by the Office of Management and Budget. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

## V. Regulatory Impact Analysis

### *A. Statement of Need*

This final rule meets the requirements of our regulations at § 418.306(c), which requires annual issuance, in the **Federal Register,** of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs, or previously used MSAs. This final rule will also update payment rates for each of the categories of hospice care described in § 418.302(b) for FY 2016 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. In addition, the payment rate updates may be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act). In 2010, the Congress amended section 1814(i)(6) of the Act with section 3132(a) of the Affordable Care Act. The amendment authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and for other purposes. The data collected may be used to revise the methodology for determining the payment rates for routine home care and other services included in hospice care, no earlier than October 1, 2013. In accordance with section 1814(i)(6)(D) of the Act, this final rule will provide an update on hospice payment reform research and analyses and implement an SIA payment in accordance with the requirement to revise the methodology for determining hospice payments in a budget-neutral manner. Finally, section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices and this rule discusses changes in the requirements for the hospice quality reporting program in accordance with section 1814(i)(5) of the Act.

### *B. Introduction*

We have examined the impacts of this final 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 Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 1995; Pub. L. 104–4), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This final rule has been designated as economically significant under section 3(f)(1) of Executive Order 12866 and thus a major rule under the Congressional Review Act. Accordingly, we have prepared a regulatory impact analysis (RIA) that, to the best of our ability, presents the costs and benefits of the rulemaking. This final rule was also reviewed by OMB.

### *C. Overall Impact*

The overall impact of this final rule is an estimated net increase in Federal Medicare payments to hospices of $160 million, or 1.1 percent, for FY 2016. The $160 million increase in estimated payments for FY 2016 reflects the distributional effects of the 1.6 percent FY 2016 hospice payment update percentage ($250 million increase), the use of updated wage index data and the phase-out of the wage index budget neutrality adjustment factor (−0.7 percent/$120 million decrease) and the implementation of the new OMB CBSA delineations for the FY 2016 hospice wage index with a 1-year transition (0.2 percent/$30 million increase). The elimination of the wage index budget neutrality adjustment factor (BNAF) was part of a 7-year phase-out that was finalized in the FY 2010 Hospice Wage Index final rule (74 FR 39384), and is not a policy change. The RHC rates and the SIA payment, outlined in section III.B, will be implemented in a budget neutral manner in the first year of implementation, as required per section 1814(i)(6)(D)(ii) of the Act. In section III.B, we are also finalizing our proposal make the SIA payments budget neutral annually. The RHC rate budget neutrality factors and the SBNF used to reduce the overall RHC rate are outlined in section III.C.3. Therefore, the RHC rates and the SIA payment will not result in an overall payment impact for the Medicare program or hospices.

### *D. Detailed Economic Analysis*

Table H1, Column 3 shows the combined effects of the use of updated wage data (the FY 2015 pre-floor, pre-reclassified hospital wage index) and the phase-out of the BNAF (for a total BNAF reduction of 100 percent), resulting in an estimated decrease in FY 2016 payments of 0.7 percent ($ −120 million). Column 4 of Table 29, shows the effects of the 50/50 blend of the FY 2016 hospice wage index values (based on the use of FY 2015 pre-floor, pre-reclassified hospital wage index data) under the old and the new CBSA delineations, resulting in an estimated increase in FY 2016 payments of 0.2 percent ($30 million). Column 5 displays the estimated effects of the RHC rates, resulting in no overall change in FY 2016 payments for hospices as this will be implemented in a budget neutral manner. Column 6 shows the estimated effects of the SIA payment, resulting in no change in FY 2016 payments for hospices as this will be implemented in a budget neutral manner through a reduction to the overall RHC rate for FY 2016. Column 7 shows the effects of the FY 2016 hospice payment update percentage. The 1.6 percent hospice payment update percentage is based on a 2.4 percent inpatient hospital market basket update for FY 2016 reduced by a 0.5 percentage point productivity adjustment and by 0.3 percentage point

as mandated by the Affordable Care Act. The estimated effects of the 1.6 percent hospice payment update percentage will result in an increase in payments to hospices of approximately $250 million. Taking into account the 1.6 percent hospice payment update percentage ($250 million increase), the use of updated wage data and the phase-out of the BNAF (−$120 million), and the adoption of the new OMB CBSA delineations with a 1-year transition for the FY 2016 hospice wage index ($30 million), Column 8 shows that hospice payments are estimated to increase by $160 million ($250 million − $120 million + $30 million = $160 million), or 1.1 percent, in FY 2016. For the purposes of our impact analysis, we use the utilization observed in the most complete hospice claims data available at the time of rulemaking (FY 2014 hospice claims submitted as of March 31, 2015). Presenting these data gives the hospice industry a more complete picture of the effects on their total revenue based on the use of updated hospital wage index data and the BNAF phase-out, the adoption of the new OMB CBSA delineations with a 1-year transition, the SIA payment, and the FY 2016 hospice payment update percentage as discussed in this final rule. 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. As illustrated in Table 29, the combined effects of all of the changes vary by specific types of providers and by location. We note that some individual hospices within the same group may experience different impacts on payments than others due to: the distributional impact of the FY 2016 wage index and phase-out of the BNAF; the extent to which hospices had varying volume in the number of RHC days in days 1–60 of the hospice episode versus days 61 and beyond; the number, length and type (discipline) of visits provided to patients during the last 7 days of life; and the degree of Medicare utilization.

TABLE 29—ESTIMATED HOSPICE IMPACTS BY FACILITY TYPE AND AREA OF THE COUNTRY, FY 2016

| | Providers | Updated FY 2016 wage index data and phase-out of BNAF (% change) | 50/50 Blend of FY 2016 wage index values under old and new CBSA delineations (% change) | Routine home care rates (days 1 thru 60 and days 61+) | FY 2016 SIA payment (% change) | FY 2016 Hospice payment update percentage (% change) | Total FY 2016 policies (% change) |
|---|---|---|---|---|---|---|---|
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| All Hospices | 4,067 | −0.7 | 0.2 | 0.0 | 0.0 | 1.6 | 1.1 |
| Urban Hospices | 3,060 | −0.7 | 0.3 | 0.0 | 0.0 | 1.6 | 1.2 |
| Rural Hospices | 1,007 | −0.3 | −0.2 | 0.3 | 0.0 | 1.6 | 1.4 |
| Urban Hospices—New England | 140 | 0.0 | 0.1 | 0.9 | 0.0 | 1.6 | 2.6 |
| Urban Hospices—Middle Atlantic | 253 | −0.7 | −0.2 | 0.6 | 0.0 | 1.6 | 1.3 |
| Urban Hospices—South Atlantic | 416 | −1.1 | 0.3 | −0.5 | −0.1 | 1.6 | 0.2 |
| Urban Hospices—East North Central | 392 | −0.8 | 0.7 | −0.2 | 0.1 | 1.6 | 1.4 |
| Urban Hospices—East South Central | 166 | −0.7 | 0.5 | −0.2 | 0.0 | 1.6 | 1.2 |
| Urban Hospices—West North Central | 222 | −0.7 | 0.6 | 0.6 | 0.2 | 1.6 | 2.3 |
| Urban Hospices—West South Central | 602 | −1.1 | 0.6 | −0.9 | −0.1 | 1.6 | 0.1 |
| Urban Hospices—Mountain | 305 | −0.6 | 0.2 | −0.2 | −0.1 | 1.6 | 0.9 |
| Urban Hospices—Pacific | 527 | −0.1 | 0.0 | 0.8 | 0.0 | 1.6 | 2.3 |
| Urban Hospices—Outlying | 37 | 0.0 | 0.3 | −0.7 | −0.3 | 1.6 | 0.9 |
| Rural Hospices—New England | 24 | −0.3 | 0.0 | 2.4 | 0.2 | 1.6 | 3.9 |
| Rural Hospices—Middle Atlantic | 42 | 0.3 | −0.1 | 1.3 | 0.4 | 1.6 | 3.5 |
| Rural Hospices—South Atlantic | 142 | −0.6 | 0.0 | −0.1 | −0.1 | 1.6 | 0.8 |
| Rural Hospices—East North Central | 137 | −0.7 | −0.4 | 0.6 | 0.2 | 1.6 | 1.3 |
| Rural Hospices—East South Central | 137 | −0.1 | −0.1 | −0.6 | −0.2 | 1.6 | 0.6 |
| Rural Hospices—West North Central | 186 | −0.3 | −0.1 | 1.7 | 0.2 | 1.6 | 3.1 |
| Rural Hospices—West South Central | 185 | −0.1 | −0.1 | −0.6 | −0.1 | 1.6 | 0.7 |
| Rural Hospices—Mountain | 104 | −1.4 | −0.6 | 0.3 | 0.0 | 1.6 | −0.1 |
| Rural Hospices—Pacific | 47 | 2.1 | 0.1 | 2.5 | 0.1 | 1.6 | 6.4 |

TABLE 29—ESTIMATED HOSPICE IMPACTS BY FACILITY TYPE AND AREA OF THE COUNTRY, FY 2016—Continued

| | Providers | Updated FY 2016 wage index data and phase-out of BNAF (% change) | 50/50 Blend of FY 2016 wage index values under old and new CBSA delineations (% change) | Routine home care rates (days 1 thru 60 and days 61+) | FY 2016 SIA payment (% change) | FY 2016 Hospice payment update percentage (% change) | Total FY 2016 policies (% change) |
|---|---|---|---|---|---|---|---|
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| Rural Hospices—Outlying | 3 | −0.8 | −0.2 | 1.4 | −0.2 | 1.6 | 1.8 |
| 0–3,499 RHC Days (Small) | 886 | −0.5 | 0.1 | 2.6 | 0.0 | 1.6 | 3.8 |
| 3,500–19,999 RHC Days (Medium) | 1,923 | −0.6 | 0.2 | 0.5 | 0.0 | 1.6 | 1.7 |
| 20,000+ RHC Days (Large) | 1,258 | −0.7 | 0.3 | −0.1 | 0.0 | 1.6 | 1.1 |
| Non-Profit Ownership | 1,073 | −0.6 | 0.2 | 1.0 | 0.1 | 1.6 | 2.3 |
| For Profit Ownership | 2,449 | −0.7 | 0.3 | −0.7 | −0.1 | 1.6 | 0.4 |
| Govt/Other Ownership | 545 | −0.6 | 0.2 | 0.5 | 0.1 | 1.6 | 1.8 |
| Freestanding Facility Type | 3,070 | −0.7 | 0.2 | −0.2 | 0.0 | 1.6 | 0.9 |
| HHA/Facility-Based Facility Type | 997 | −0.4 | 0.2 | 1.4 | 0.1 | 1.6 | 2.9 |
| Rate of RHC NF/SNF Days is in Lowest Quartile (Less than or equal to 3.1) | 1,016 | −0.5 | 0.1 | 0.5 | −0.1 | 1.6 | 1.6 |
| Rate of RHC NF/SNF Days is in 2nd Quartile (Greater than 3.1 and Less than or equal to 16.7) | 1,017 | −0.6 | 0.1 | 0.3 | 0.0 | 1.6 | 1.4 |
| Rate of RHC NF/SNF Days is in 3rd Quartile (Greater than 16.7 and less than or equal to 35.5) | 1,017 | −0.8 | 0.3 | 0.0 | 0.0 | 1.6 | 1.1 |
| Rate of RHC NF/SNF Days is in Highest Quartile (Greater than 35.5) | 1,017 | −0.7 | 0.4 | −0.4 | 0.0 | 1.6 | 0.9 |

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

**Note(s):** The 1.6 percent hospice payment update percentage for FY 2016 is based on an estimated 2.4 percent inpatient hospital market basket update, reduced by a 0.5 percentage point productivity adjustment and by 0.3 percentage point. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in section 1814(i)(1)(C)(ii)(VII) or section 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity as set out at section 1886(b)(3)(B)(xi)(II) 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 set out under section 1814(i)(1)(C)(v) of the Act).

**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 and Table*

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 30 below, we have prepared an accounting statement showing the classification of the expenditures associated with this final rule. Table H2 provides our best estimate of the increase in Medicare payments under the hospice benefit as a result of the changes presented in this final rule for 4,067 hospices in our impact analysis file constructed using FY 2014 claims as of March 31, 2015.

TABLE 30—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS, FROM FY 2015 TO FY 2016

[In $millions]

| Category | Transfers |
|---|---|
| **FY 2015 Hospice Wage Index and Payment Rate Update** | |
| Annualized Monetized Transfers | $160. |
| From Whom to Whom? | Federal Government to Hospices. |

*F. Conclusion*

In conclusion, the overall effect of this final rule is an estimated $160 million increase in Medicare payments to hospices. The $160 million increase in estimated payments for FY 2016 reflects the distributional effects of the 1.6 percent FY 2016 hospice payment update percentage ($250 million increase), the use of updated wage index data and the phase-out of the wage index budget neutrality adjustment factor (−0.7 percent/$120 million decrease) and the implementation of the new OMB CBSA delineations for FY 2016 hospice wage index with a 1-year transition (0.2 percent/$30 million increase). The SIA payment does not result in aggregate changes to estimate hospice payments for FY 2016 as this will be implemented in a budget neutral manner through an overall reduction to the RHC payment rate for all hospices.

2. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than $7.5 million to $38.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. HHS's practice in interpreting the RFA is to consider effects economically ''significant'' only if they reach a threshold of 3 to 5 percent or more of total revenue or total costs. As noted above, the combined effect of the updated wage data and the BNAF phase-out (−0.7 percent decrease or −$120 million) the implementation of the new OMB CBSA delineations for FY 2016 hospice wage index with a 1-year transition (0.2 percent increase or $30 million), the SIA payment (no estimated aggregate impact on payments), and the FY 2016 hospice payment update percentage (1.6 percent increase or $250 million) results in an overall increase in estimated hospice payments of 1.1 percent, or $160 million, for FY 2016. Therefore, the Secretary has determined that this final rule will not create a significant economic impact on a substantial number of small entities.

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

3. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2015, that threshold is approximately $144 million. This final rule is not anticipated to have an effect on State, local, or tribal governments, in the aggregate, or on the private sector of $144 million or more.

## VI. Federalism Analysis and Regulations Text

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

## List of Subjects

*42 CFR Part 418*

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

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

## PART 418—HOSPICE CARE

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

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

## Subpart G—Payment for Hospice Care

■ 2. Section 418.302 is amended by—

■ a. Adding paragraph (b)(1)(i) and (ii).

■ b. Amending paragraphs (d)(1), (d)(2), (e) introductory text, (f)(2) and (f)(5)(ii) by removing the word ''intermediary'' and adding in its place the words ''Medicare Administrative Contractor''.

■ c. Revising paragraph (e)(1).

The revisions and additions read as follows:

### § 418.302 Payment procedures for hospice care.

* * * * *

(b)

(1) * * *

(i) *Service intensity add-on.* Routine home care days that occur during the last 7 days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment.

(ii) The service intensity add-on payment shall be equal to the continuous home care hourly payment rate, as described in paragraph (e)(4) of this section, multiplied by the amount of direct patient care actually provided by a RN and/or social worker, up to 4 hours total per day.

* * * * *

(e) * * *

(1) Payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day

(except as set out in paragraph (b)(1)(i) of this section).

* * * * *

■ 3. Section 418.306 is amended by revising the section heading and paragraphs (a), (b) and (c) to read as follows.

**§ 418.306 Annual update of the payment rates and adjustment for area wage differences.**

(a) *Applicability.* CMS establishes payment rates for each of the categories of hospice care described in § 418.302(b). The rates are established using the methodology described in section 1814(i)(1)(C) of the Act and in accordance with section 1814(i)(6)(D) of the Act.

(b) *Annual update of the payment rates.* The payment rates for routine home care and other services included in hospice care are the payment rates in effect under this paragraph during the previous fiscal year increased by the hospice payment update percentage increase (as defined in sections1814(i)(1)(C) of the Act), applicable to discharges occurring in the fiscal year.

(1) For fiscal year 2014 and subsequent fiscal years, in accordance with section 1814(i)(5)(A)(i) of the Act, in the case of a Medicare-certified hospice that submits hospice quality data, as specified by the Secretary, the payment rates are equal to the rates for the previous fiscal year increased by the applicable hospice payment update percentage increase.

(2) For fiscal year 2014 and subsequent fiscal years, in accordance with section 1814(i)(5)(A)(i) of the Act, in the case of a Medicare-certified hospice that does not submit hospice quality data, as specified by the Secretary, the payment rates are equal to the rates for the previous fiscal year increased by the applicable hospice payment update percentage increase, minus 2 percentage points. Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the payment amounts for a subsequent fiscal year.

(c) *Adjustment for wage differences.* Each hospice's labor market is determined based on definitions of Metropolitan Statistical Areas (MSAs) issued by OMB. CMS will issue annually, in the **Federal Register,** a hospice wage index based on the most current available CMS hospital wage data, including changes to the definition of MSAs. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C) of this chapter. The payment rates established by CMS are adjusted by the Medicare contractor to reflect local differences in wages according to the revised wage data.

* * * * *

**§ 418.308 [Amended]**

■ 4. Section 418.308(c) is amended by removing the phrase ''(that is, by March 31st)''.

■ 5. Section 418.309 is amended by revising the introductory text and paragraph (a) to read as follows:

**§ 418.309 Hospice aggregate cap.**

A hospice's aggregate cap is calculated by multiplying the adjusted cap amount (determined in paragraph (a) of this section) by the number of Medicare beneficiaries, as determined by one of two methodologies for determining the number of Medicare beneficiaries for a given cap year described in paragraphs (b) and (c) of this section.

(a) *Cap Amount.* The cap amount was set at $6,500 in 1983 and is updated using one of two methodologies described in paragraphs (a)(1) and (a)(2) of this section.

(1) For accounting years that end on or before September 30, 2016 and end on or after October 1, 2025, the cap amount is adjusted for inflation by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CPI from March 1984 to the fifth month of the cap year.

(2) For accounting years that end after September 30, 2016, and before October 1, 2025, the cap amount is the cap amount for the preceding accounting year updated by the percentage update to payment rates for hospice care for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year as determined pursuant to section 1814(i)(1)(C) of the Act (including the application of any productivity or other adjustments to the hospice percentage update).

* * * * *

Dated: July 27, 2015

**Andrew M. Slavitt,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

Dated: July 28, 2015

**Sylvia M. Burwell,**

*Secretary, Department of Health and Human Services.*

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