

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS-1714-P]

RIN 0938-AT71

Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the hospice wage index, payment rates, and cap amount for fiscal year 2020. This rule proposes to rebase the continuous home care, general inpatient care, and the inpatient respite care per diem payment rates in a budget-neutral manner to more accurately align Medicare payments with the costs of providing care. In addition, this rule proposes to modify the election statement by requiring an addendum that includes information aimed at increasing coverage transparency for patient under a hospice election. Finally, this rule proposes changes to the Hospice Quality Reporting Program.

DATES: *Comments:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 18, 2019.

ADDRESSES: In commenting, refer to file code CMS-1714-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (choose only one of the ways listed):

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1714-P, P.O. Box 8010, Baltimore, MD 21244-1850.

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

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

Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1714-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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

FOR FURTHER INFORMATION CONTACT: For general questions about hospice payment policy, send your inquiry via email to: hospicepolicy@cms.hhs.gov. Debra Dean-Whittaker, (410) 786-0848 for questions regarding the CAHPS® Hospice Survey. Cindy Massuda, (410) 786-0652 for questions regarding the hospice quality reporting program.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments. Wage index addenda will be available only through the internet on our website at: (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html>.)

I. Executive Summary

A. Purpose

This rule proposes updates to the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2020, as required under section 1814(i) of the Social Security Act (the Act). This rule proposes to rebase the continuous home care (CHC), general inpatient care (GIP), and inpatient respite care (IRC) per diem payment rates in a budget neutral manner to more accurately align payments with the costs of providing care, using the hospice payment reform authority under section 1814(i)(6) of the Act. This rule also proposes a change to the hospice wage index to remove the 1-year lag in data by using the current year's hospital wage data to establish the hospice wage index. In addition, this rule proposes to modify the hospice election statement by requiring an addendum that includes information aimed at increasing coverage transparency for patients under a hospice election. Finally, this rule proposes changes to the Hospice Quality Reporting Program.

B. Summary of the Major Provisions

Section III.A of this proposed rule describes the FY 2020 hospice per diem payment rebasing methodology, cost reports and calculations. Using the hospice payment reform authority under section 1814(i)(6) of the Act, section III.A.3 proposes to rebase the FY 2020 per diem payment rates for CHC, IRC, and GIP levels of care. As required in section 1814(i)(6)(D)(ii) of the Act, any changes to hospice payment rates must be done in a budget neutral manner. As such, section III.A.3 also proposes a reduction to the routine home care (RHC) payment amounts for FY 2020 in order to maintain overall budget neutrality. Section III.B.1 of this proposed rule proposes to eliminate the 1-year lag of the pre-floor, pre-reclassified hospital wage index that is used in calculating the hospice wage index. Section III.B.2 proposes updates to the hospice wage index and makes the application of the updated wage data budget neutral for all four levels of hospice care. In section III.B.4 of this proposed rule, we discuss the proposed FY 2020 hospice payment update percentage of 2.7 percent. Section III.B.5 outlines the proposed FY 2020 hospice payment rates that result from the policies proposed in section III.A. Section III.B.6 of this proposed rule updates the hospice cap amount for FY 2020 by the hospice payment update percentage discussed in section III.B.4 of this rule. Section III.C proposes to modify the hospice election statement content requirements at § 418.24(b) to increase coverage transparency for patients under a hospice election by notifying beneficiaries if there are services that will not be covered by the hospice.

In addition, section III.D describes a request for information (RFI) as it relates to the Medicare Fee-For-Service (FFS) Hospice benefit and coordination of care at end-of-life. Finally, in section III.E of this proposed rule, we discuss updates to the Hospice Quality Reporting Program (HQRP), including: The development of claims-based and outcome measures, measure concepts, and the hospice assessment tool. We also provide updates on the public reporting change for the "Hospice Visits When Death is Imminent" measure pair, the posting of publicly available government data to the CMS Hospice Compare website and the CAHPS® Hospice Survey.

C. Summary of Impacts

The overall economic impact of this proposed rule is estimated to be \$540

million in increased payments to hospices for FY 2020.

II. Background

A. Hospice Care

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

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

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

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

with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary’s care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

If, in the judgment of the hospice interdisciplinary team, which includes the hospice physician, the patient’s symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home and continue to receive routine home care. Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. Continuous home care may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with our regulations at § 418.204. A minimum of 8 hours of nursing care, or nursing and aide care, must be furnished on a particular day to qualify for the continuous home care rate (§ 418.302(e)(4)).

Hospices must comply with applicable civil rights laws,¹ including Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, under which covered entities must take appropriate steps to ensure effective communication with patients and patient care representatives with disabilities, including the provisions of auxiliary aids and services. Additionally, they must take reasonable steps to ensure meaningful access for individuals with limited English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these

¹ Hospices are also subject to additional Federal civil rights laws, including the Age Discrimination Act, Section 1557 of the Affordable Care Act, and conscience and religious freedom laws.

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

B. Services Covered by the Medicare Hospice Benefit

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

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

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

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

C. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and our regulations in 42 CFR part 418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment in one of four prospectively-determined rate categories of hospice care (RHC, CHC, IRC, and GIP), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected). This per diem payment is to include all of the hospice services and items needed to manage the beneficiary’s care, as required by section 1861(dd)(1) of the Act. There has been little change in the hospice payment structure since the benefit’s inception. The per diem rate based on level of care was established in 1983, and this payment structure remains today with some adjustments, as noted below.

1. Omnibus Budget Reconciliation Act of 1989

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

2. Balanced Budget Act of 1997

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

3. FY 1998 Hospice Wage Index Final Rule

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

4. FY 2010 Hospice Wage Index Final Rule

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

5. The Affordable Care Act

Starting with FY 2013 (and in subsequent FYs), the market basket percentage update under the hospice payment system referenced in sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(1)(C)(iii) of the Act is subject to annual reductions related to changes in economy-wide productivity, as specified in section 1814(i)(1)(C)(iv) of the Act.

In addition, sections 1814(i)(5)(A) through (C) of the Act, as added by section 3132(a) of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148), required hospices to begin submitting quality data, based on measures 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 have their market basket percentage increase reduced by 2 percentage points.

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the PPACA, required, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary’s hospice care prior to the 180th day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, we finalized in the FY 2011 Hospice Wage Index final rule (75 FR 70435) that the 180th day recertification and subsequent recertifications would correspond to the beneficiary’s third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the PPACA, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the PPACA could capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determined to be appropriate. The data

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

6. FY 2012 Hospice Wage Index Final Rule

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

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

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

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50479) also finalized a requirement that the election form include the beneficiary’s choice of attending physician and that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians.

In addition, the FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50496) provided background, eligibility criteria, survey respondents,

and implementation of the Hospice Experience of Care Survey for informal caregivers. Hospice providers were required to begin using this survey for hospice patients as of 2015.

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

8. IMPACT Act of 2014

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

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

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

In addition to the hospice payment reform changes discussed, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47186) implemented changes mandated by the IMPACT Act, in which the cap amount for accounting years that end after September 30, 2016

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

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

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

D. Trends in Medicare Hospice Utilization

Since the implementation of the hospice benefit in 1983, 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 1.5 million in FY 2018. Medicare hospice expenditures have risen from \$2.8 billion in FY 2000 to approximately \$18.7 billion in FY 2018. CMS' Office of the Actuary (OACT) projects that hospice expenditures are expected to continue to increase, by approximately 8.5 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.

As a part of our ongoing analysis of hospice utilization trends, we examined the distribution of total hospice days by level of care. A review of claims over the last 10 years shows that RHC remains the highest utilized level of care, accounting for an average of 97.6 percent of total hospice days; GIP accounting for 1.7 percent of total hospice days; CHC accounting for 0.4 percent of total hospice days; and, IRC accounting for 0.3 percent of total hospice days.

There have also been notable changes in the diagnosis patterns among Medicare hospice enrollees. At the time of the implementation of the Medicare hospice benefit, cancer diagnoses were the most frequently reported diagnoses. However, there has been a significant increase in the reporting of neurologically-based diagnoses, including Alzheimer's disease, which has been the top-reported diagnosis on hospice claims since 2014. The increase in the reporting of neurological conditions as the principal diagnosis on hospice claims corresponds to a clarification in the FY 2014 hospice final rule (78 FR 48242) on diagnosis reporting where "debility" and "adult failure to thrive" are no longer permitted to be reported as principal diagnosis codes on hospice claims. Our ongoing analysis of diagnosis reporting trends finds that neurological and organ-based failure conditions remain top-reported principal diagnoses.

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47201), we clarified that hospices are to report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, effective October 1, 2015. Analysis of FY 2018 hospice claims show that 100 percent of claims included at least one diagnosis, 90.3 percent of claims included at least two

diagnoses, and 82.1 percent of claims included at least three diagnoses.

Finally, we examined hospice trends relating to hospice length of stay. The number of days that a hospice beneficiary receives care under a hospice election is referred to as the hospice length of stay (LOS). Length of stay can be analyzed in several ways. Total *lifetime* length of stay includes the sum of all days of hospice care across

all hospice elections. This would mean if a beneficiary had one hospice election, was discharged alive, and then reelected the benefit at a later date, the sum of both elections would count towards their lifetime length of stay. Average length of stay refers to the number of hospice days during a single hospice election at the date of live discharge or death. The median length of stay reflects the 50th percentile and

is often the most meaningful comparison measure for evaluating LOS data as the total lifetime length of stay and the average length of stay are affected by extremely short and extremely long lengths of stay. Table 1 lists the clinical categories of principal diagnoses reported on hospice claims along with the corresponding number of decedents, as well as the average, total lifetime and median lengths of stay.

TABLE 1—AVERAGE LENGTH OF STAY IN DAYS FOR HOSPICE USERS IN FY 2018

| Category | Number of hospice users who are discharged at the end of FY 2018 | Average lifetime length of stay | Median lifetime length of stay | Number of elections (elections ending in FY 2018) | Average length of election | Median length of election |
|--|--|---------------------------------|--------------------------------|---|----------------------------|---------------------------|
| Alzheimer's, Dementia, and Parkinson's | 203,349 | 167.4 | 50 | 215,547 | 124.9 | 37 |
| CVA/Stroke | 55,321 | 142.7 | 30 | 58,457 | 109.7 | 24 |
| Cancers | 286,131 | 53.6 | 17 | 303,507 | 46.0 | 16 |
| Chronic Kidney Disease | 27,527 | 43.9 | 8 | 28,740 | 34.6 | 7 |
| Heart (CHF and Other Heart Disease) | 203,613 | 106.0 | 24 | 216,161 | 83.7 | 20 |
| Lung (COPD and Pneumonias) | 114,399 | 103.9 | 18 | 122,579 | 79.6 | 16 |
| Other | 335,777 | 78.7 | 13 | 352,288 | 61.3 | 12 |
| All Diagnoses | 1,226,117 | 96.6 | 19 | 1,297,279 | 75.3 | 17 |

Source: FY 2018 hospice claims data from CCW on January 29, 2019.

Note(s): Only beneficiaries whose last day of hospice in FY 2018 was not associated with a discharge status code of “30” were counted (“30” indicates they remained in hospice). Lifetime length of stay is determined using all hospice elections over the beneficiary's lifetime.

III. Provisions of the Proposed Rule

A. Proposed Rebasings of the Continuous Home Care, Inpatient Respite Care, and General Inpatient Care Payment Rates for FY 2020

1. Background

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

We originally set the base payment rates for each level of care in 1983 using information from a relatively small set (n=26) of hospices that were participating in a CMS hospice demonstration. As a result of technological changes to providing hospice care that have occurred since the early 1980's, as well as changes in the patient population that uses the hospice benefit, it is possible that the current per diem payment rates for the Medicare hospice benefit do not align accurately with the costs of providing care. Since the establishment of the base payment rates, they have been updated through the years to primarily account for inflation, but we have not implemented any large scale changes to reflect non-inflationary changes in cost over time, with the exception of the bifurcation of the RHC payment rate and the creation of the SIA payment finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule for implementation on January 1, 2016 (80 FR 47142).

For over a decade, MedPAC and other organizations reported findings that suggested that the hospice benefit's fixed per-diem payment system was 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 2002,² 2004,³ 2006,⁴ 2008,⁵ and 2009⁶ 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

² Medicare Payment Advisory Commission (MedPAC). “Report to the Congress: Medicare Payment Policy.” Washington, DC. March 2002. P. 48. http://www.medpac.gov/docs/default-source/reports/Mar02_Entire_report.pdf.

³ Medicare Payment Advisory Commission (MedPAC). “Report to the Congress: Medicare Payment Policy.” Washington, DC. March 2004. http://www.medpac.gov/docs/default-source/reports/Mar04_Entire_reportv3.pdf?sfvrsn=0.

⁴ Medicare Payment Advisory Commission (MedPAC). “Report to the Congress: Medicare Payment Policy.” Washington, DC. March 2006. http://www.medpac.gov/docs/default-source/reports/Mar06_EntireReport.pdf?sfvrsn=0.

⁵ Medicare Payment Advisory Commission (MedPAC). “Report to the Congress: Medicare Payment Policy.” Washington, DC. March 2008. http://www.medpac.gov/docs/default-source/reports/mar08_entirereport.pdf?sfvrsn=0.

⁶ Medicare Payment Advisory Commission (MedPAC). “Report to the Congress: Medicare Payment Policy.” Washington, DC. March 2009. P. 347 <http://www.medpac.gov/docs/default-source/reports/march-2009-report-to-congress-medicare-payment-policy.pdf?sfvrsn=0>.

profitable, long middle segments. In its March 2009 report, “Reforming Medicare’s Hospice Benefit,” As mentioned previously, this led to CMS finalizing a bifurcated payment rate for RHC level of care in the FY 2016 (80 FR 47172) hospice final rule. These dual RHC payment rates were derived from observed resource utilization reflecting the cost of providing care for the clinical service (labor) components of the RHC across the entire episode, that 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). For the establishment of the dual RHC rates we used visit intensity as 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. In addition to the dual RHC payment rates, CMS also finalized a Service Intensity Add-on (SIA) payment payable for services during the last 7 days of the beneficiary’s life, equal to the CHC hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse (RN) or social worker that occurs during the last 7 days (80 FR 47177). While we made changes to the RHC payment rate based on resource utilization and established an SIA payment to account for differences in resource use throughout the course of hospice care, we did not make any changes to the per diem

payment rates for CHC, IRC or GIP. Likewise, the dual RHC rates did not reflect the total costs of providing hospice care given the lack of more comprehensive information on the costs associated with the services provided by hospices to Medicare beneficiaries by level of care at that time.

Hospices are paid per day, regardless of whether any services are provided to a hospice patient on any given day. The CHC level of care is paid based on an hourly rate when a hospice patient, who is not in an inpatient facility, receives hospice care consisting predominantly of nursing care on a continuous basis at home. The hospice must provide a minimum of 8 hours of care in a 24 hour period in order for such services to be covered as CHC. The GIP level of care is a day in which a hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings. The IRC level of care is short-term care provided only when necessary to relieve the family members or other persons caring for the hospice patient at home. IRC can be provided for up to 5 consecutive days.

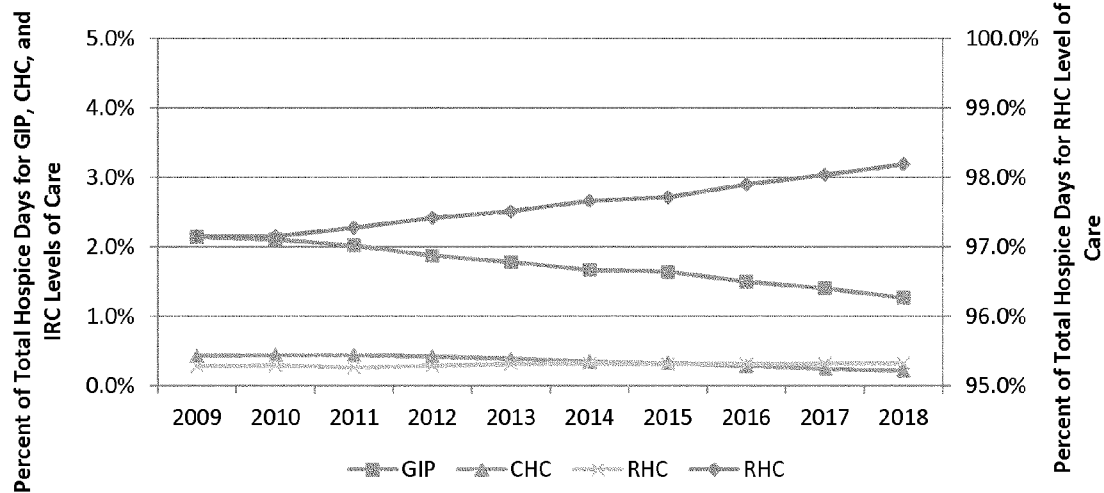
While hospices must provide all levels of care to meet the hospice Conditions of Participation (CoPs), there is much lower utilization of CHC, IRC, and GIP compared to RHC. As part of our ongoing reform work, we analyzed the trends in hospice days and payments by level of care. Our analysis found that between FY 2009 and FY 2018 RHC days as a percent of total

hospice days increased from 97.2 percent to 98.2 percent. Conversely, during this time frame CHC and GIP days as a percent of total hospice days decreased. CHC days as a percent of total hospice days decreased by half, and in FY 2018, CHC was only 0.2 percent of total hospice days compared to 0.4 percent in FY 2009. GIP days as a percent of total hospice days decreased from 2.1 percent in FY 2009 to 1.3 percent in FY 2018. Finally, the percent of IRC days remained relatively constant from FY 2009–FY 2018 at 0.3 percent of total hospice days in FY 2018. The results were similar for the percent of payments by level of care. RHC payments as a percent of total hospice payments increased from 89.2 percent in FY 2009 to 93.4 percent in FY 2018. CHC payments as a percent of total payments decreased from 1.9 percent of payments in FY 2009 to 1.0 percent in FY 2018. GIP payments decreased from 8.7 percent of total hospice payments in FY 2009 to 5.3 percent in FY 2018. Finally, IRC payments as a percent of total hospice payments increased slightly to 0.3 percent in 2018 from 0.2 percent in 2009.⁷ Figure 1 shows the trends of total hospice days by level of care for FYs 2009–2018 and Figure 2 shows the trends of total hospice payments by level of care for FYs 2009–2018.

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⁷ FY 2009 through FY 2018 hospice claims data, accessed from the Chronic Conditions Data Warehouse (CCW) on January 3, 2019.

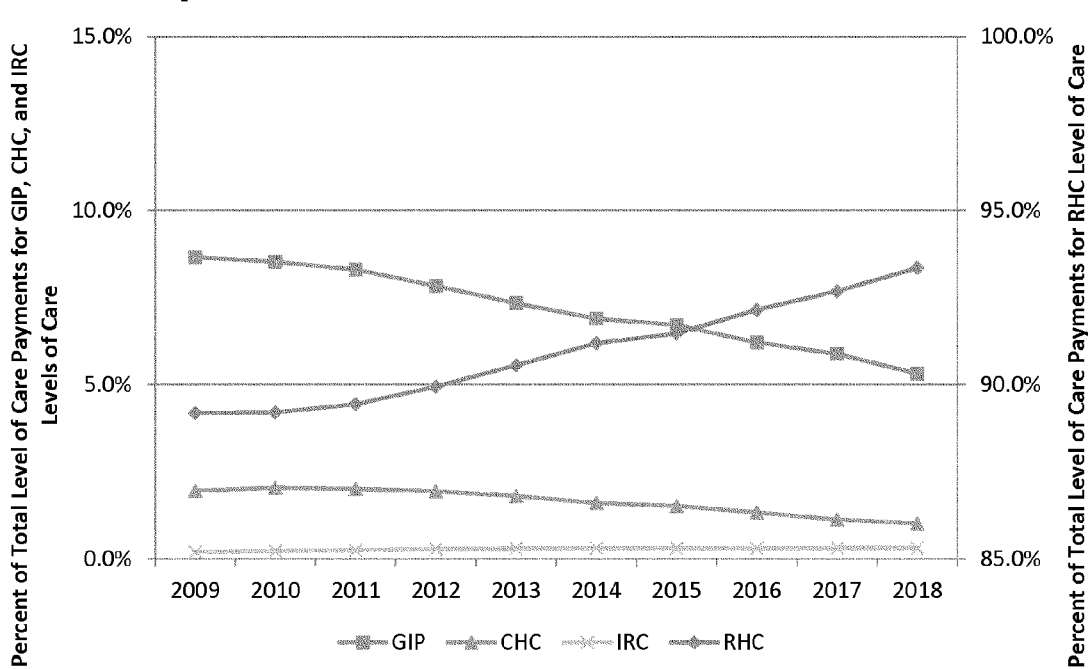
Figure 1: Percent of Total Hospice Days by Level of Care for Fiscal Years 2009 - 2018



Source: Analysis of data for FY 2009 through FY 2018 accessed from the CCW on January 3, 2019.

Note(s): Line items were assigned to a level of care using the revenue codes 0651(RHC), 0652 (CHC), 0655 (IRC) and 0656 (GIP). RHC, IRC, and GIP days were counted by adding the revenue units for any line item with those revenue codes. CHC days were counted by adding up the number of line items with revenue code 0652. Payments for each line item were summed.

Figure 2: Percent of Total Level of Care Payments by Level of Care for Fiscal Years 2009 - 2018



Source: Analysis of data for FY 2009 through FY 2018 accessed from the CCW on January 3, 2019.

Note(s): Line items were assigned to a level of care using the revenue codes 0651(RHC), 0652 (CHC), 0655 (IRC) and 0656 (GIP). RHC, IRC, and GIP days were counted by adding the revenue units for any line item with those revenue codes. CHC days were counted by adding up the number of line items with revenue code 0652. Payments for each line item were summed.

As discussed previously in this proposed rule, 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 for other purposes. The data collected may be used to revise the methodology for determining the payment rates 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. 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.

The Secretary is required to consult with hospice programs and the MedPAC regarding additional data collection and payment reform options. We have transparently conducted payment reform analysis and have released research findings to the public in our 2013 and 2014 Technical Reports,^{8,9} as well as in the FYs 2014 and 2015 Hospice Wage Index and Payment Rate Update final rules (78 FR 48234 and 80 FR 50452). These research findings and concepts provided a basis for the initial step toward hospice payment reform.

Based on stakeholder suggestions, we began collecting additional information on the hospice claims form as of April 1, 2014.¹⁰ These changes include the reporting of line-item visit data for hospice staff providing GIP to hospice patients in skilled nursing facilities (site of service Healthcare Common Procedure Coding System (HCPCS) code Q5004) or in hospitals (site of service HCPCS codes Q5005, Q5007, Q5008). This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for RHC and CHC. It also includes certain calls by hospice social workers (as described in CR 6440,

Transmittal 1738),¹¹ on a line-item basis, with call and call length reported, as is done for RHC and CHC. However, we did not change the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit (site of service HCPCS code Q5006). Only visits/calls made by the paid hospice staff are to be reported; hospices do not report visits by non-hospice staff. Additionally, hospices are required to report visits and length of visits (rounded to the nearest 15 minute increment), for nurses, aides, social workers, and therapists who are employed by the hospice, that occur on the date of death, after the patient has passed away. Finally, these changes included the requirement that hospice agencies report injectable and non-injectable prescription drugs for the palliation and management of the terminal illness and related conditions on their claims. Both injectable and non-injectable prescription drugs would be reported on claims on a line-item basis per fill, based on the amount dispensed by the pharmacy. Over-the-counter drugs would not be reported on the claim. However, we removed the requirement to report detailed drug data on the hospice claim as a way to reduce burden for hospices. Instead, hospices are now only required to report total durable medical equipment (DME) and medication charges on the claim. This change became effective October 1, 2018.

Effective for cost reporting periods beginning on or after October 1, 2014, freestanding hospices are required to file the revised hospice cost report (Form CMS-1984-14).¹² Provider-based hospices began using the revised cost report form for cost reporting periods beginning on or after October 1, 2015. The revised cost report expands data collection requirements to supply greater detail related to hospice costs by level of care. Hospices are required to report all direct patient care costs by multiple cost categories into the respective level of care. Within the revised cost report changes in 2014, there were modifications in the manner in which general service costs and statistical information is accumulated by the hospice and an expansion of the general service cost centers. Instructions for completing the freestanding hospice cost report (Form CMS-1984-14) are found in the Medicare Provider

Reimbursement Manual—Part 2, Chapter 43.¹³

In the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142) we stated that we received many suggestions for ways to improve data collection to support larger payment reform efforts in the future and that we expected to analyze additional claims and cost report data reported by hospices to determine whether additional regulatory proposals to reform and strengthen the Medicare hospice benefit would be warranted (80 FR 47161). Likewise, MedPAC, the Government Accountability Office (GAO), and the Office of the Inspector General (OIG) have all recommended that CMS collect more comprehensive data to better evaluate trends in utilization of the Medicare hospice benefit.

We continued to analyze hospice claims and cost report data to determine whether additional changes need to be made to more accurately align hospice payment with the costs of providing care. Specifically, we have continued to examine whether there is a misalignment between payment and costs for CHC, IRC, and GIP. In its March 2018 Report to the Congress, MedPAC stated Medicare's payment rates for the CHC, IRC and GIP levels of care appear to be lower than the average and median costs per day for freestanding providers and suggested that rebalancing the payment rates may be warranted.¹⁴

Additionally, we received public comments on past rules that indicated the payment rates for CHC, IRC and GIP are much different from the average costs of providing those levels of care. Specifically, several commenters expressed concerns regarding the rates for these levels of care being insufficient to acquire and maintain contracts for inpatient levels of care. In response to the FY 2015 Hospice Wage Index and Payment Rate Update proposed rule (79 FR 26538), a commenter suggested that hospices have difficulty contracting for respite care in many areas because the hospice respite rate may be \$5 to \$50 less per day than the facility's Medicaid rate. This commenter also stated that nursing facilities in many states do not want to accept less than their Medicaid

⁸ Medicare Hospice Payment Reform: Hospice Study Technical Report. Cambridge, MA. April 2013. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Study-Technical-Report.pdf>.

⁹ Medicare Hospice Payment Reform: Analyses to Support Payment Reform. Cambridge, MA. May 2014. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Study-Technical-Report.pdf>.

¹⁰ CMS Transmittal 2864. "Additional Data Reporting Requirements for Hospice Claims." Available at: <https://www.cms.gov/Regulations-and-Guidance/Transmittals/Downloads/R2864CP.pdf>.

¹¹ CR 6440, Transmittal 1738. <https://www.cms.gov/Regulations-and-Guidance/Transmittals/downloads/R1738CP.pdf>.

¹² <https://www.cms.gov/Regulations-and-Guidance/Transmittals/Downloads/R1P243.pdf>.

¹³ The Provider Reimbursement Manual—Part 2. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html>.

¹⁴ Medicare Payment Advisory Commission (MedPAC). "Hospice Services." Report to the Congress: Medicare Payment Policy. Washington, DC. March 2018. P. 341. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch12_sec.pdf?sfvrsn=0.

room and board rate. In response to the FY 2016 Hospice Wage Index and Payment Rate Update proposed rule (80 FR 25832) one commenter stated that some hospitals do not want to accept the GIP hospice rate which leaves hospices unable to provide the GIP level of care. Finally, in response to the FY 2019 Hospice Wage Index and Payment Rate Update proposed rule (83 FR 20934), one commenter stated that providers have reported that it is more difficult to obtain new GIP contracts with hospitals and skilled nursing facilities and to retain existing contracts as they are renegotiated because the hospice GIP rate is less than the hospital would receive for an acute inpatient stay. Some commenters also suggested that hospices must pay the contracting facility the full daily hospice reimbursement rate in order to secure a contract for inpatient care. The Hospice CoPs at § 418.108 require that inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility. Therefore, hospices that do not provide inpatient care and are unable to negotiate contracts with hospitals or skilled nursing facilities (SNFs) for

inpatient level of care are in violation of the hospice CoPs. However, through public comments and anecdotal reports from hospices, we continue to hear that the payment rates for CHC, IRC, and GIP are a significant factor in whether or not hospices can secure the necessary contracts to provide these levels of care.

Using information collected from the revised hospice cost report, for the first time, we are able to estimate hospices' average costs per day by level of care. As required by section 1814(i)(1)(A) of the Act, payment for hospice services must be an amount equal to the costs which are reasonable and related to providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations. Therefore, given that we now have several years' worth of cost report data from the revised hospice cost report, we calculated the average costs per day by level of care and compared such costs to the per diem payment rates by level of care to determine if there is a misalignment between payment and costs and whether the per diem payment rates for CHC, IRC, and GIP should be rebased. To conduct this analysis, we used a variety of different

data sources, including cost reports and hospice claims data. We also used additional sources such as prior hospice final rules that detail wage indices and payment rate updates, as well as the CMS Provider of Services (POS) file. The methodology of this analysis is described below.

2. Methodology and Analysis of Costs per Day for Continuous Home Care, Inpatient Respite Care, and General Inpatient Care

a. Hospice Cost Report Data

Our analysis was based on information obtained from the Healthcare Cost Report Information System (HCRIS). The Hospice Cost Report Data contains cost and statistical data for freestanding and provider-based hospice providers. The dataset is normally updated quarterly and is available on the last day of the month following the quarter's end. To determine the average per-day costs of providing hospice services, we conducted initial analysis of both freestanding and provider-based Medicare hospice cost reports. We used the following HCRIS data files as of December 31, 2018, for cost reports from FY 2017 to support our analyses:¹⁵

| | |
|---|---|
| Freestanding Hospices | http://downloads.cms.gov/Files/hcris/HOSPC14-ALL-YEARS.zip . |
| Skilled Nursing Facility (SNF) Based Hospices | https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year-Items/SNF10-DL-2017.html . |
| Home Health Agency (HHA) Based Hospices ... | https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year-Items/HHA-DL-2017.html . |
| Hospital Based Hospices | https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year-Items/HOSPITAL10-DL-2017.html . |

The HCRIS data as of December 31, 2018, were downloaded February 2019. To create the initial analytic file, we took a number of data cleaning steps to exclude certain hospices. Specifically, we made the following exclusions:¹⁶

Exclusion 1: A small number of hospices (as represented by CMS Certification Number (CCN)) had multiple FY 2017 cost reports in the HCRIS cost report data file. For those hospices, we kept the cost report that

covered the greatest length of time in FY 2017;¹⁷

Exclusion 2: We eliminated SNF, HHA, and hospital cost reports that did not contain a hospice CCN; and

Exclusion 3: We eliminated 15 cost reports (as represented by CCN) due to the following reasons:

a. Sometimes within a provider-based cost report, the same CCN was listed multiple times (that is, there might be two separate reports of RHC costs for the

same CCN within a provider-based cost report). In order to limit each hospice to one single cost report, we selected the cost report with the highest RHC cost.¹⁸

b. Sometimes a CCN appeared in a freestanding cost report as well as appeared in a provider-based cost report.

Table 2 below shows the starting sample and the number of hospice cost reports after applying the exclusions listed above.

TABLE 2—NUMBER OF MEDICARE HOSPICE COST REPORTS AFTER EXCLUSIONS

| Type of cost report | Starting sample | Exclusion 1 | Exclusion 2 | Exclusion 3 ¹⁹ |
|--------------------------------------|-----------------|-------------|-------------|---------------------------|
| Freestanding | 3,253 | 3,213 | 3,213 | 3,207 |
| Skilled Nursing Facility (SNF) | 14,883 | 14,068 | 26 | 26 |

¹⁵ Cost reports from FY 2017 had a start date on or after October 1, 2016 and before October 1, 2017.

¹⁶ For the three exclusions, we found information on hospice CCNs using Worksheet S-2 of provider-based cost reports. Specifically, we used information from Worksheet S-2, Part I, line 14 and its subscripts for hospital-based cost reports,

Worksheet S-2, Part I, line 12 and its subscripts for SNF based cost reports, and Worksheet S-2, line 3.50 and its subscripts for home health agency cost reports. Additionally, a single provider-based cost report could contain information on multiple hospice CCNs, in which case we considered each hospice CCN as a separate cost report.

¹⁷ We determined the length of the cost report by subtracting the cost reports fiscal year begin date from the cost reports fiscal year end date.

¹⁸ For example, in one home health agency-based cost report, the home health agency reported costs for the same hospice CCN three different times on the same cost report.

TABLE 2—NUMBER OF MEDICARE HOSPICE COST REPORTS AFTER EXCLUSIONS—Continued

| Type of cost report | Starting sample | Exclusion 1 | Exclusion 2 | Exclusion 3 ¹⁹ |
|--------------------------------|-----------------|-------------|-------------|---------------------------|
| Home Health Agency (HHA) | 10,227 | 10,090 | 476 | 473 |
| Hospital | 5,480 | 5,413 | 425 | 419 |

Next, we constructed a series of flags to identify cost reports that did not fill out fields that we would expect hospices to report (for example, nursing services). We identified those cost report fields using information from the Provider Reimbursement Manual—Part 2, Provider Cost Reporting Forms and Instructions, Chapter 43, Form CMS–1984–14, Transmittal 3, dated April 13, 2018, that updated cost reporting instructions for freestanding hospice cost reports.²⁰ These instructions describe a number of new Level I edit conditions that required freestanding hospices to fill out certain parts of their cost reports. Specifically, section 4395

of this transmittal revised edit 1050A in the new Level I edits portion of “Table 6—Edits” to require that values entered into Worksheet A, column 7, lines 1, 2, 3, 4, 13, 28, 33, 37, and 38 must be greater than zero; and the sum of lines 14 and 42.50 must also be greater than zero. These Level I edits went into effect for freestanding hospice cost reports with a reporting period that ended on or after December 31, 2017.

Next, to remove outliers from this analysis, we applied another set of exclusions as described in the FY 2019 Hospice Wage Index and Payment Rate Update proposed rule (83 FR 20948). Specifically, we described how a

trimming methodology is applied to cost reports so that statistical anomalies were minimized. For each calculated outcome (for example, average RHC costs per day), we excluded those values that are above the 99th percentile and those values that are below the 1st percentile. We refer to this trim as the “1% Trim”. The data we exclude vary for each level of care. For example, we may exclude a hospice’s data when calculating RHC costs per day, but not exclude it when calculating GIP costs per day. After all the described exclusions were applied, table 3 below shows how many freestanding cost reports were used for this analysis.

TABLE 3—NUMBER OF FREESTANDING COST REPORTS AFTER THE LEVEL I EDITS EXCLUSION AND 1% TRIM

| Level of care | Number of cost reports after exclusions | Number of days by level of care (FY 2017) |
|---------------|---|---|
| RHC | 1,098 | 41,329,675 |
| GIP | 809 | 783,335 |
| CHC | 437 | 187,498 |
| IRC | 906 | 134,146 |

Note: We begin with the 3,207 freestanding cost reports that remained after applying exclusions in 1–3 (table 2). After applying the Level I edits, 1,120 freestanding cost reports remained. Not all cost reports contain information on each level of care. Numbers shown indicate the number of cost reports available for analysis for each level of care after all exclusions, including the 1% trim are applied.

Primarily, due to the small sample size of provider-based hospices after these exclusions (see explanation below), we ultimately decided to only use freestanding hospice cost reports. As shown in table 2, there were 918 provider-based cost reports (that is, 26 SNF, 473 HHA, and 419 hospital) before applying the new Level I edits to the provider-based hospice cost reports. After applying the new Level I edits there were 96 provider-based cost reports remaining. Likewise, in MedPAC’s March 2017 Report to Congress, they stated that included in the costs of provider-based hospices are overhead costs allocated from the parent provider, which contribute to provider-based hospices having higher costs than freestanding hospices. The Commission believes payment policy should focus on the efficient delivery of services to

Medicare beneficiaries. If freestanding hospices are able to provide high-quality care at a lower cost than provider-based hospices, payment rates should be set accordingly, and the higher costs of provider-based hospices should not be a reason for increasing Medicare payment rates.²¹ Industry representatives also suggested various edits to improve the quality of data submitted on the cost report before being accepted by the Medicare Administrative Contractors (MACs) (83 FR 20949).

However, we did consider using both freestanding and provider-based cost reports, with all cost report adjustments, including Level I edits, to rebase the payment rates for CHC, IRC, and GIP. We also considered not applying the Level I edits to the freestanding cost reports for this rebasing analysis. Both

of these alternative approaches are described in section V.E. of this proposed rule. The remaining discussion in this section will focus on our analysis of freestanding hospice cost reports for FY 2017. This analysis focused on the costs per day by level of care found within the hospice cost reports and reported on Worksheet C, column 3, Lines 3, 8, 13 and 18.

b. Hospice Claims Data

We created an analytic data set based on Medicare hospice claims downloaded from the Chronic Condition Data Warehouse—Virtual Research Data Center (CCW VRDC) to examine hospice utilization on specific days during FY 2017. We assigned a wage index (using the FY 2017 hospice wage indices) to each day of hospice service based on the core-based

¹⁹ FY 2017 cost reports had a start date on or after October 1, 2016 and before October 1, 2017.

²⁰ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3P243.pdf>.

²¹ Medicare Payment Advisory Commission (MedPAC). “Hospice Services.” *Report to the Congress: Medicare Payment Policy*. Washington, DC. March 2018. P. 341. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch12_sec.pdf?sfvrsn=0.

statistical area (CBSA) where a particular day's hospice services took place.²² We merged information from the June 2018 release of the CMS POS file to identify characteristics of the hospice including: Ownership type, census division (based on the hospice's state), and whether the hospice's main office was located either in an urban or rural location. This data was used in the subsequent section in calculating costs per day by level of care.

c. Calculating Costs per Day by Level of Care

In order to compute the average cost per day for each level of care using information from the freestanding

hospice cost reports, after applying the exclusions, we made several adjustments to the average cost calculations, as described below.

Costs reported on Medicare cost reports vary due to many factors, including variation in costs driven by geographic location. For example, all else equal, hospices in high wage areas (for example, New York City) may have higher costs compared to hospices in low wage areas. Daily payment rates for hospice are adjusted to account for geographic differences in wage rates. However, this geographic wage adjustment is only applied to the labor share of the base payment rate. The labor share for RHC and CHC is 68.71

percent, for GIP it is 64.01 percent and for IRC, it is 54.13 percent. Medicare adjusts for these wage differences by first multiplying the base payment rate paid to hospices by the labor share of the base payment rate. That value is then multiplied by the wage index assigned to the CBSA where the hospice provided services to the patient. Therefore, it is important to calculate average costs after removing any regional differences that may be driven by wages, otherwise we would over-adjust for wage differences across regions. For example, we remove the wage differences in RHC costs by calculating the following value for each hospice:

Adjusted RHC cost per day = RHC cost per day from 2017 cost reports * (0.6871) /

Hospice's average wage index for all RHC days in FY 2017 +

RHC cost per day from 2017 cost reports * (1 - 0.6871)

Note: 0.6871 is the labor share used to wage index adjust RHC payments

We perform a similar calculation for the other levels of care using the corresponding cost per day from FY 2017 cost reports and the appropriate labor share for CHC, IRC, and GIP. For example, the adjusted GIP cost per day uses the same formula, but instead includes GIP cost per day from FY 2017 cost reports, the hospice's average wage index for all GIP days in the formula, and the GIP labor share of 64.01 percent.

Due to exclusions mentioned previously, not all hospices that submitted claims during FY 2017 have a corresponding cost report in our final sample. As a result, the characteristics of the sample of cost reports used to calculate average cost per day for each level of care do not necessarily match up with the characteristics of all

hospices that submitted claims during FY 2017. If not accounted for, our sample of cost reports may over-represent certain types of hospices. To correct for this, we categorize each hospice in our sample by facility type,²³ ownership type,²⁴ urban/rural status,²⁵ and size.²⁶ For each category of hospices and the calculations for each level of care, we use the following steps:

1. Using claims, we compute the total number of days provided in FY 2017 by all hospices within a particular category;

2. We compute the total number of days, as reported on the claims provided in FY 2017, using only the hospices in our trimmed sample of cost reports within a particular category (Table 3); and

3. For each level of care and each category of hospices, we construct a ratio using the value in Step 1 over the value in Step 2.

For each cost report in our sample, we multiply each provider's days (as reported on claims) by level of care by the ratio in order to make the sample cost reports more representative of the overall population of hospices. We then multiply the provider's average per diem cost as reported on the cost report times the number of adjusted days from the prior step to yield total costs by level of care for that provider. We then compute the weighted average for each level of care by summing across hospices the total costs by level of care divided by the sum of the adjusted days across the cost reports in our sample.²⁷

$$\text{Weighted Average IRC Cost Per Day} = \frac{\sum_{i=1}^n \text{Cost}_i * \text{Number of Days}_i}{\sum_{i=1}^n \text{Number of Days}_i}$$

Note: Where Cost_i represents the IRC cost per day reported by hospice *i* and Number of Days_i represents the number of IRC days provided by hospice *i* as found in FY 2017 hospice claims and adjusted upward by the ratio described above.

²² <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index/FY-2017-Final-Hospice-Wage-Index.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>

²³ Freestanding versus provider-based.

²⁴ We only divide the freestanding cost reports into ownership type categories. We use the

ownership type categories from the POS: For-profit, government, non-profit, and other. Due to limited sample size we do not break out the provider-based hospices into ownership type.

²⁵ Urban/rural status is reported on the POS and corresponds to the mailing address of the hospice.

²⁶ We divide hospices into three categories based on their number of RHC days in FY 2017: Large (>=20,000 RHC days), medium (3,500–19,999 RHC days), and small (0–3,499 RHC days).

²⁷ The formula describes the average cost per day calculation for IRC, however, the same formula can be adapted for each level of care.

We compute the weighted average equation for each level of care. For example, we use a separate equation to calculate the average GIP cost per day that uses GIP costs and GIP days. The equation as described above is an approach to calculate the average per day cost for each level of care. However, Medicare pays for the CHC level of care using a per hour rate instead of a per day rate. We calculated each hospice's hourly cost of CHC by taking their CHC cost per day from the hospice cost report and dividing it by their average number of hours of CHC provided on CHC days occurring in FY 2017 as reported on each hospice's claims. Each hospice's CHC cost per hour (adjusted by average number of hours of CHC) is then averaged (using the weighted average formula discussed above) across all hospices in our sample to create the overall average of CHC cost per hour. To convert the CHC cost per hour into a CHC cost per day we multiply the average CHC cost per hour by 24 hours. It is important to note that each hospice's hourly CHC cost is based on their average number of CHC minutes

per day, which is less than 24 hours. That means a full CHC per day payment (which covers 24 hours) will be larger than the average CHC cost per day (which covers a time period less than 24 hours).

Applying all of the steps as described above, average costs per day by level of care in FY 2017 are listed in Table 4 below:

TABLE 4—AVERAGE COST PER DAY BY LEVEL OF CARE, FY 2017

| Level of care | Average cost per day |
|------------------------------------|----------------------|
| RHC | \$130.83 |
| CHC (24 Hours) ²⁸ | 1,307.76 |
| CHC (Per Hour) | 54.49 |
| IRC | 438.98 |
| GIP | 953.96 |

The current payment system pays hospices a two-tiered rate for RHC. RHC days during the first 60 days are paid a higher per diem rate compared to any RHC days after day 60. Hospices do not report RHC costs separately for the first 60 days versus RHC days after day 60.

However, we can estimate the RHC costs in the first 60 days versus after 60 days by making the same assumption that was made to calculate the two-tiered payment. That is, in the FY 2016 hospice final rule (80 FR 47166), we calculated resource use ratios to determine the differences in resource utilization for the first 60 days and any RHC days after day 60. For the creation of the two-tiered RHC rate (80 FR 47166), the following ratios were used:

- Days 1 through 60: The ratio of average resource use for RHC days in days 1 through 60 to average resource use across all RHC days was 1.2603 to 1.
- Days 61 and beyond: The ratio of average resource use for RHC days after day 60 to the average resource use across all RHC days was 0.8722 to 1.

We multiplied the average cost per day for RHC in FY 2017 by the corresponding resource use ratio to calculate the average cost per day for the first 60 days and any RHC days after 60 days. The resulting average cost per day for RHC is shown in Table 5.

TABLE 5—AVERAGE RHC COSTS (FY 2017) PER DAY FOR DAYS 1 THROUGH 60 AND DAYS 61+

| RHC level of care | Average cost per day | Resource use ratio | Average cost per day in FY 2017 (based on days of RHC) |
|-------------------|----------------------|--------------------|--|
| Days 1–60 | \$130.83 | 1.2603 | \$164.89 |
| Days 61+ | 130.83 | 0.8722 | 114.11 |

To determine if there is any misalignment between the average costs of providing CHC, IRC and GIP and the per diem payment rates for these levels of care, we inflated the average costs in FY 2017 to FY 2019 dollars. We did this

by multiplying the average FY 2017 costs by level of care by the hospice market basket update payment update for FY 2018 (82 FR 36649) and FY 2019 (83 FR 38630) less the multifactor productivity adjustments (MFP). Table 6

below shows the estimated average costs for CHC, IRC and GIP for FY 2019 (that is, taking the average FY 2017 cost per day by each level of care inflated to 2019 dollars).

TABLE 6—ESTIMATED AVERAGE COSTS (FY 2019) FOR CHC, IRC AND GIP

| Level of care | FY 2017 average costs | FY 2018 hospice market basket update less productivity adjustment | FY 2019 hospice market basket update less productivity adjustment | FY 2019 estimated average costs |
|----------------------|-----------------------|---|---|---------------------------------|
| CHC (per Hour) | \$54.49 | × 1.021 | × 1.021 | \$56.80 |
| IRC | 438.98 | × 1.021 | × 1.021 | 457.61 |
| GIP | 953.96 | × 1.021 | × 1.021 | 994.45 |

We also analyzed the average costs of the RHC for the first 60 days and any RHC days after day 60 inflated from FY 2017 dollars to FY 2019 dollars by

applying the hospice market basket update less the MFP adjustments. The results in Table 7 show the estimated

average costs for RHC by days for FY 2019.

²⁸ Based off a full CHC per day payment (which covers 24 hours).

TABLE 7—ESTIMATED AVERAGE COSTS FOR RHC (FY 2019) DAYS 1 THROUGH 60 AND DAYS 61+

| Level of care | FY 2017 average costs | FY 2018 hospice market basket update less productivity adjustment | FY 2019 hospice market basket update less productivity adjustment | FY 2019 estimated average costs |
|---------------------|-----------------------|---|---|---------------------------------|
| RHC Days 1–60 | \$164.89 | × 1.021 | × 1.021 | \$171.89 |
| RHC Days 61+ | 114.11 | × 1.021 | × 1.021 | 118.95 |

We then compared the FY 2019 average costs for CHC, IRC and GIP to the FY 2019 payment rates for these three levels of care. Our analysis shows that there is a misalignment between average costs and payment for these

three levels of care. Table 8 below shows: The percent of total hospice days by level of care; the estimated average FY 2019 costs by level of care; the current FY 2019 per diem payment rates; and the estimated percent increase

to the payment rates to more accurately align the per diem payments for CHC, IRC and GIP with the costs of providing these levels of care.

TABLE 8—COMPARISON OF FY 2019 AVERAGE COSTS TO PAYMENTS FOR CHC, IRC AND GIP

| Level of care | Percent of days by level of care in FY 2018 * | Estimated FY 2019 average costs per day | FY 2019 per diem payment rates | Estimated percent payment increase needed to align with costs |
|---------------|---|--|-----------------------------------|---|
| CHC | 0.2 | \$1,363.26/\$56.80 (per hour) ²⁹ .. | \$997.38/\$41.56 (per hour) | +36.6 |
| IRC | 0.3 | \$457.61 | \$176.01 | +160.0 |
| GIP | 1.3 | \$994.45 | \$758.07 | +31.2 |

* RHC days accounted for 98.2 percent of all hospice days in FY 2018.

The payment rates for CHC, IRC, and GIP are significantly less than the average costs of providing care. We also compared the FY 2019 average costs for

RHC for the first 60 days and any RHC days after day 60 to the FY 2019 payment rates for RHC and the percentage difference between payment

and average costs and the results are shown in Table 9 below.

TABLE 9—COMPARISON OF FY 2019 AVERAGE COSTS TO PAYMENT FOR RHC

| Level of care | Estimated FY 2019 average costs per day | FY 2019 payment rates | Percent difference between payment and costs |
|---------------------|---|-----------------------|--|
| RHC Days 1–60 | \$171.89 | \$196.25 | +14.2 |
| RHC Days 61+ | 118.95 | 154.21 | +29.6 |

For RHC, the payment rates significantly exceed the average costs of providing care for this level of care for the first 60 days and any RHC days after day 60.

3. Proposed Rebasing of the CHC, IRC, and GIP Payment Rates for FY 2020

As mentioned above, section 1814(i)(1)(A) of the Act requires that payment for hospice services must be an amount equal to the costs which are reasonable and related to the cost of providing hospice care. As described above, the average costs of providing CHC, IRC and GIP are significantly higher than the payment amounts for these three levels of care. Using the

hospice payment reform authority under section 1814(i)(6) of the Act, we are proposing to rebase the payment rates for CHC, IRC, and GIP by setting these payment amounts equal to the FY 2019 estimated average costs per day, as described in the methodology above, before application of the hospice payment update percentage outlined in section III.C of this proposed rule. We are proposing to rebase the payment rates for CHC, IRC, and GIP as follows:

TABLE 10—PROPOSED REBASED PAYMENT RATES FOR CHC, IRC, AND GIP *

| Level of care | Proposed rebased payment rates * |
|-------------------------------|---|
| Continuous Home Care (CHC). | \$56.80 per hour/ \$1,363.26 (per day). ³⁰ |
| Inpatient Respite Care (IRC). | \$435.82.** |
| General Inpatient Care (GIP). | \$994.45. |

* Prior to application of the hospice payment update percentage of 2.7 percent outlined in section III.B of this proposed rule.

** IRC payment rate accounts for 5 percent coinsurance (\$457.61/1.05 = \$435.82).

Although there is no coinsurance amount for RHC, CHC or GIP, the

²⁹ Based off a full CHC per day payment (which covers 24 hours).

³⁰ Based off a full CHC per day payment (which covers 24 hours).

amount of coinsurance for each respite care day is equal to 5 percent of the payment made by Medicare for a respite care day. Section 1813(a)(4)(A)(ii) of the Act states that the amount payable for hospice care shall be reduced in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1814(i) to that program for respite care. To ensure payments (both paid by Medicare and collected from the beneficiary via coinsurance) under a rebased IRC rate equal the average per-diem cost of IRC, we set the rebased IRC payment rate equal to the average per-diem cost of IRC divided by 1.05. The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began. The individual hospice coinsurance period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

Section 1814(i)(6)(D)(ii) of the Act requires that any revisions to the methodology for determining the payment rates for other services included in hospice care to be done in a budget-neutral manner in the fiscal year in which such revisions in payment are implemented as would have been made for care in the fiscal year if such revisions had not been implemented. Therefore, in order to offset the proposed increases in payment rates to the CHC, IRC, and GIP levels of care, we are proposing to reduce the RHC payment rates by 2.71 percent in order to implement rebasing in a budget-neutral manner in FY 2020. Reducing the RHC payment rate to a level equal to the estimated RHC costs would require a reduction in the RHC payment rate that exceeds the proposed 2.71 percent. While we are rebasing the per diem payment rates for CHC, GIP, and IRC to more accurately align the payment with costs, the reduction to the RHC payment rates is not considered rebasing as the 2.71 percent reduction does not bring the RHC payment in alignment with the costs of providing this level of care. The purpose of the 2.71 percent reduction to the RHC payment rates is to ensure that the revisions to the payment rates for CHC,

GIP and IRC are made in a budget-neutral manner, in accordance with the law.

To calculate the proposed 2.71 percent reduction to the RHC payment rates, we first calculate two sets of payments using different payment parameters.

1. Total payments for hospice days provided during FY 2018 under the existing FY 2019 payment rates and FY 2019 wage indices.³¹

2. Total payments for hospice days provided during FY 2018 under a new RHC payment rate and the rebased payment rates for CHC, IRC, and GIP.

We set the RHC payment rate in step (2) equal to the value that makes total payments between step (1) and step (2) equivalent. We calculate that rate using the following steps:

1. We calculate the difference in Medicare payments when using the rebased CHC, IRC, and GIP payment rates instead of the payment rates in place during FY 2019.

2. We calculate one minus the value from Step (1) over the RHC payments made under the payment rates in place during FY 2019.³²

3. We multiply the value in Step (2) by each RHC payment rate (the first 60 days and any RHC days after day 60) in place during FY 2019 to establish the budget-neutral RHC payment rates (the first 60 days and any RHC days after day 60).

The calculated payment rates in Step (3) will make the total payments made under the rebased FY 2019 payment rates equal to the total payments made under the existing FY 2019 payment rates.

The results of this calculation demonstrate that in order to rebase CHC, IRC, and GIP levels of care in a budget-neutral manner, the RHC payment rates would need to be reduced by 2.71 percent. The proposed 2.71 percent reduction would be applied to the RHC payment rates for the first 60 days and RHC days after day 60 (that is we would take each of the RHC payment rates and multiply by the 0.9729 to determine the FY 2019 RHC payment rates).

To summarize, we are proposing: To rebase the payment rates for CHC and GIP and set these rates equal to their estimated FY 2019 average costs per day

(see Table 10 above); we are proposing to rebase the payment rate for IRC and set this rate equal to the estimated FY 2019 average cost per day, with a reduction of 5 percent to the estimated FY 2019 average cost per day to account for coinsurance (see Table 10 above); and we are proposing a 2.71 percent reduction to the RHC payment rates to offset the proposed increases to the CHC, IRC, and GIP payment rates as the proposed increases in the payment rates for these three levels of care must be implemented in a budget-neutral manner in accordance with section 1814(i)(6)(D)(ii) of the Act. While the per diem payments were a reasonable way to pay hospices, we think the proposal to rebase the per diem payments for CHC, GIP, and IRC better reflects the costs of providing care. This proposal is in accordance with section 1814(i)(A) of the Act that provides the authority to set such payments reasonable to the cost of providing hospice care.

It is our intent to ensure that payment rates under the hospice benefit align as closely as possible with the average costs hospices incur when efficiently providing covered services to beneficiaries. This proposal is not intended to place an arbitrary limit on hospice services and we believe the rebased rates for CHC, IRC, and GIP may help appropriately increase access to these levels of care. We continue to expect hospices to adhere to the long-standing policy to provide "virtually all" care during a hospice election as articulated in the 1983 Hospice Care proposed and final rules as well as most recently in FY 2019 Hospice Wage Index and Payment Rate Update final rule. We also believe this proposal is responsive to industry concerns regarding the challenges in securing needed contracts with facilities to provide inpatient levels of care by more accurately aligning Medicare payments for hospice services for higher cost levels of care. We are soliciting comments on our proposal to rebase the payment rates for CHC, IRC, and GIP, which results in an increase in the payment rates to those three levels of care, and to maintain overall budget neutrality through a proposed reduction to the RHC payment rates.

We believe that rebasing the per diem payment amounts for CHC, GIP, and IRC is appropriate in order to better align payments with the costs of providing care and that potential, subsequent increases in utilization of those levels of care would not necessarily be inappropriate. However, we are also soliciting comment on whether rebasing the payment amounts for CHC, GIP, and

³¹ FY 2018 is the most, current full year of data available.

³² Using the average per-diem costs generated from our sample of freestanding hospice cost reports, rebasing CHC, IRC, and GIP results in extra payments of \$465,983,031.15 for those levels of care. The RHC payments that were made under the payment rates in place during FY 2019 were \$17,218,209,794.15. One minus the value of the extra payments over the RHC payments equals 0.9729.

IRC could create an adverse incentive for providers to inappropriately steer patients to a higher, more specialized level of care when that level of care is not medically indicated.

B. Proposed FY 2020 Hospice Wage Index and Rate Update

1. Proposed Wage Index Lag Elimination

Historically we have calculated the hospice wage index values by using the prior fiscal year's pre-floor, pre-reclassified hospital wage index. In an effort to align with the Inpatient Prospective Payment System (IPPS) and other payment systems, we are proposing to change the hospice wage index methodology. Specifically, we are proposing to change from our established policy of using the pre-floor, pre-reclassified acute care hospital wage index from the prior fiscal year as the basis for the hospice wage index, and instead to align with the same

timeframe used by the IPPS and other payment systems. In other words, we are proposing to use the pre-floor, pre-reclassified hospital wage index from the current fiscal year as the basis for the hospice wage index. Under this proposal, the FY 2020 hospice wage index would be based on the FY 2020 pre-floor, pre-reclassified IPPS hospital wage index rather than on the FY 2019 pre-floor, pre-reclassified IPPS hospital wage index.

Using the concurrent pre-floor, pre-reclassified hospital wage index would result in the most up-to-date wage data being the basis for the hospice wage index, increasing payment accuracy. It would also result in more consistency and parity in the wage index methodology used by Medicare. Medicare's skilled nursing facility (SNF), home health and acute care hospital prospective payment systems already use the most current wage index data as the basis for their wage indices.

Thus, if our proposal is finalized, the wage-adjusted Medicare payments of various provider types would be based upon wage index data from the same timeframe. We are considering similar policies to use the concurrent pre-floor, pre-reclassified hospital wage index data in other Medicare payment systems, such as inpatient psychiatric facilities and inpatient rehabilitation facilities.

Overall, the impact between the FY 2020 wage index with the 1-year lag and the proposed FY 2020 wage index removing the 1-year lag is 0.0 percent due to the wage index standardization factor, which ensures that wage index updates and revisions are implemented in a budget-neutral manner. The anticipated impact on Medicare hospice payments due to the change in the wage index methodology can be found in table 11 below.

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Table 11: Estimated Impact on Medicare Hospice Payments, FY 2020 Hospice Wage Index with and without 1-Year Lag

| | Hospices | FY 2020 Wage Index with 1-year Lag Minus FY 2019 Wage Index (Percentage Change) | FY 2020 Wage Index without 1-Year Lag Minus FY 2020 Wage Index with 1-Year Lag (Percentage Change) |
|--|----------|--|---|
| All Hospices | 4,569 | 0.0% | 0.0% |
| Hospice Type and Control | | | |
| Freestanding/Non-Profit | 601 | -0.1% | 0.1% |
| Freestanding/For-Profit | 2,819 | 0.1% | -0.1% |
| Freestanding/Government | 39 | 0.1% | -0.3% |
| Freestanding/Other | 322 | -0.2% | 0.1% |
| Provider/HHA Based/Non-Profit | 396 | -0.3% | 0.0% |
| Provider/HHA Based/For-Profit | 194 | -0.2% | 0.0% |
| Provider/HHA Based/Government | 101 | -0.3% | 0.2% |
| Provider/HHA Based/Other | 97 | -0.1% | 0.0% |
| Subtotal: Freestanding Provider Type | 3,781 | 0.0% | 0.0% |
| Subtotal: Provider/HHA Based Provider Type | 788 | -0.3% | 0.0% |
| Subtotal: Non-Profit | 997 | -0.1% | 0.1% |
| Subtotal: For Profit | 3,013 | 0.1% | -0.1% |
| Subtotal: Government | 140 | 0.0% | -0.1% |
| Subtotal: Other | 419 | -0.2% | 0.1% |
| Hospice Type and Control: Rural | | | |
| Freestanding/Non-Profit | 154 | 0.0% | 0.5% |
| Freestanding/For-Profit | 328 | 0.1% | 0.2% |
| Freestanding/Government | 20 | -0.3% | 0.0% |
| Freestanding/Other | 45 | -0.2% | 0.2% |
| Provider/HHA Based/Non-Profit | 157 | -0.4% | 0.0% |
| Provider/HHA Based/For-Profit | 47 | 0.0% | 0.1% |
| Provider/HHA Based/Government | 74 | 0.0% | 0.3% |
| Provider/HHA Based/Other | 54 | -0.8% | 0.5% |
| Hospice Type and Control: Urban | | | |
| Freestanding/Non-Profit | 447 | -0.1% | 0.1% |
| Freestanding/For-Profit | 2,491 | 0.1% | -0.1% |
| Freestanding/Government | 19 | 0.2% | -0.3% |
| Freestanding/Other | 277 | -0.2% | 0.1% |
| Provider/HHA Based/Non-Profit | 239 | -0.3% | 0.0% |
| Provider/HHA Based/For-Profit | 147 | -0.3% | 0.0% |
| Provider/HHA Based/Government | 27 | -0.5% | 0.1% |
| Provider/HHA Based/Other | 43 | 0.1% | -0.1% |

| Hospice Location: Urban or Rural | | | |
|--|-------|-------|-------|
| Rural | 879 | -0.1% | 0.2% |
| Urban | 3,690 | 0.0% | 0.0% |
| Hospice Location: Region of the Country (Census Division) | | | |
| New England | 157 | -0.5% | -0.5% |
| Middle Atlantic | 281 | -0.2% | -0.1% |
| South Atlantic | 554 | -0.1% | 0.0% |
| East North Central | 543 | -0.4% | 0.0% |
| East South Central | 263 | -0.2% | 0.1% |
| West North Central | 404 | -0.3% | 0.6% |
| West South Central | 875 | 0.3% | 0.1% |
| Mountain | 458 | -0.5% | 0.2% |
| Pacific | 988 | 0.9% | -0.2% |
| Outlying | 46 | -1.3% | -0.3% |
| Hospice Size | | | |
| 0 - 3,499 RHC Days (Small) | 971 | 0.5% | 0.0% |
| 3,500-19,999 RHC Days (Medium) | 2,130 | 0.1% | 0.0% |
| 20,000+ RHC Days (Large) | 1,468 | 0.0% | 0.0% |

Note: 3 hospices with claims in FY 2018 were dropped from the analysis because they had no information on their location, facility type, or ownership status in the December 2018 POS file.

Source: FY 2018 hospice claims data as of December 31, 2018 from the CCW Research Identifiable Files (RIFs), accessed January 2019.

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We invite comments on this proposal to align the hospice wage index with that of the SNF PPS and Home Health PPS, by using the most current pre-floor, pre-reclassified IPPS hospital wage index as the basis for the hospice wage index.

2. Proposed FY 2020 Hospice Wage Index

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

In section III.B.1 above, we proposed to use the current FY's hospital wage index data to calculate the hospice wage index values. For FY 2020, the proposed hospice wage index would be based on the FY 2020 hospital pre-floor, pre-

reclassified wage index. This means that the hospital wage data used for the hospice wage index are not adjusted to take into account any geographic reclassification of hospitals including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The appropriate wage index value is applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the Core-Based Statistical Areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2020, there are two CBSAs without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia and 16180, Carson City, NV. The FY 2020 wage index value for Carson City, NV is 1.0518 and the wage

index value for Hinesville-Fort Stewart, Georgia is 0.8237.

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

FY 2020, we propose to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

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

The proposed hospice wage index applicable for FY 2020 (October 1, 2019 through September 30, 2020) is available on our website at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html>.

3. Wage Index Comment Solicitation

As we stated above, historically, we have calculated the hospice wage index values using unadjusted wage index values from another provider setting. Stakeholders have frequently commented on certain aspects of the hospice wage index values and their impact on payments. We are soliciting comments on concerns stakeholders may have regarding the wage index used to adjust hospice payments and suggestions for possible updates and improvements to the geographic adjustment of hospice payments.

4. Proposed FY 2020 Hospice Payment Update Percentage

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus 1

percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient market basket percentage increase for that FY.

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP).

The proposed hospice payment update percentage for FY 2020 is based on the estimated inpatient hospital market basket update of 3.2 percent (based on IHS Global Inc.'s fourth-quarter 2018 forecast with historical data through the third quarter 2018). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the estimated inpatient hospital market basket update for FY 2020 of 3.2 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.5 percentage point for FY 2020). In effect, the proposed hospice payment update percentage for FY 2020 would be 2.7 percent.

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

5. Proposed FY 2020 Rebased Hospice Payment Rates

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

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

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47177), we will continue to make the SIA payments budget neutral through an annual determination of the SIA budget neutrality factor (SBNF), which will then be applied to the RHC payment rates. The SBNF will be calculated for each FY using the most current and complete utilization data available at the time of rulemaking. For FY 2020, this calculation would also reflect the proposed increase in the hourly rate for CHC as a result of rebasing, discussed in section III.A.2.c of this proposed rule.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. In order to calculate the wage index

standardization factor, we simulate total payments using the proposed FY 2020 hospice wage index (no lag) and compare it to our simulation of total payments using the FY 2019 hospice wage index. By dividing payments for each level of care using the FY 2020 wage index (no lag) by payments for each level of care using the FY 2019 wage index, we obtain a wage index standardization factor for each level of care (the first 60 RHC days and RHC days after day 60 and, CHC, IRC, and GIP). The wage index standardization factors for each level of care are shown in the tables 12 and 13 below.

As discussed in section III.A.3 of this proposed rule, we are proposing to rebase the per diem payment rates for the CHC, IRC, and GIP levels of care. 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 for other purposes. The data collected may be used to revise the methodology for determining the payment rates 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. As mentioned above and outlined in the Affordable Care Act, hospice payment reform must be done in a budget-neutral manner. In other words, total estimated hospice expenditures under these rebased payment rates must equal total estimated hospice expenditures absent rebasing (we are assuming no change in utilization). In order to rebase the per diem payment amounts for CHC, IRC, and GIP in a budget-neutral manner, in section III.A.2.c we proposed that increases to

the CHC, IRC, and GIP per diem payment amounts would be offset by corresponding decreases to the RHC per diem payment amounts to maintain overall budget neutrality.

The proposed FY 2020 payment rates for RHC would be the proposed FY 2019 payment rates, reduced by a budget neutrality factor as a result of the proposed rebasing of the CHC, IRC, and GIP payment amounts, adjusted by the SIA budget neutrality factor, adjusted by the wage index standardization factor, and increased by the 2.7 hospice payment update percentage as shown in table 12. The proposed FY 2020 rebased payment rates for CHC, IRC, and GIP would be the proposed rebased FY 2019 payment rates, adjusted by the wage index standardization factor and increased by the 2.7 market basket update percent as shown in table 13.

TABLE 12—PROPOSED FY 2020 HOSPICE RHC PAYMENT RATES

| Code | Description | Proposed FY 2019 budget-neutral RHC payment rates * | SIA budget neutrality factor | Wage index standardization factor ** | Proposed FY 2020 hospice payment update | Proposed FY 2020 payment rates |
|-----------|-------------------------------------|---|------------------------------|--------------------------------------|---|--------------------------------|
| 651 | Routine Home Care (days 1–60) | \$190.93 | × 0.9924 | × 1.0054 | × 1.027 | \$195.65 |
| 651 | Routine Home Care (days 61+) | 150.03 | × 0.9982 | × 1.0054 | × 1.027 | 154.63 |

* FY 2019 RHC payment rate for days 1–60: = \$196.25 * 0.9729 = \$190.93. FY 2019 RHC payment rate for days 61+ = \$154.21 * 0.9729 = \$150.03.

** Transition from FY 2019 Wage Index to FY 2020 Wage Index without 1-Year Lag.

TABLE 13—PROPOSED FY 2020 HOSPICE CHC, IRC, AND GIP PAYMENT RATES

| Code | Description | Proposed FY 2019 rebased payment rates | Wage index standardization factor * | Proposed FY 2020 hospice payment update | Proposed FY 2020 payment rates |
|-----------|--|--|-------------------------------------|---|--------------------------------|
| 652 | Continuous Home Care Full Rate = 24 hours of care (\$56.80 = hourly rate). | \$1,363.26 | × 1.0041 | × 1.027 | \$1,405.81 |
| 655 | Inpatient Respite Care | 435.82 | × 1.0049 | × 1.027 | 449.78 |
| 656 | General Inpatient Care | 994.45 | × 1.0060 | × 1.027 | 1,027.43 |

* Transition from FY 2019 Wage Index to FY 2020 Wage Index without 1-Year Lag.

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

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

data submission requirements with respect to that FY. The proposed FY 2020 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2020 hospice payment update percentage of 2.7 percent minus 2 percentage points. These rates are shown in tables 14 and 15.

TABLE 14—PROPOSED FY 2020 HOSPICE RHC PAYMENT RATES FOR HOSPICES THAT *DO NOT* SUBMIT THE REQUIRED QUALITY DATA

| Code | Description | Proposed FY 2019 budget-neutral RHC payment rates * | SIA budget neutrality factor | Wage index standardization factor** | Proposed FY 2020 hospice payment update of 2.7% minus 2 percentage points = +0.7% | Proposed FY 2020 payment rates |
|-----------|-------------------------------------|---|------------------------------|-------------------------------------|---|--------------------------------|
| 651 | Routine Home Care (days 1–60) | \$190.93 | × 0.9924 | × 1.0054 | × 1.007 | \$191.84 |
| 651 | Routine Home Care (days 61+) | 150.03 | × 0.9982 | × 1.0054 | × 1.007 | 151.62 |

* FY 2019 RHC payment rate for days 1–60 = \$196.25 * 0.9729 = \$190.93. FY 2019 RHC rate for days 61+ = \$154.21 * 0.9729 = \$150.03.

** Transition from FY 2019 Wage Index to FY 2020 Wage Index without 1-Year Lag.

TABLE 15—PROPOSED FY 2020 HOSPICE CHC, IRC, AND GIP PAYMENT RATES FOR HOSPICES THAT *DO NOT* SUBMIT THE REQUIRED QUALITY DATA

| Code | Description | Proposed FY 2019 rebased payment rates | Wage index standardization factor * | Proposed FY 2020 hospice payment update of 2.7% minus 2 percentage points = +0.7% | Proposed FY 2020 payment rates |
|-----------|--|--|-------------------------------------|---|--------------------------------|
| 652 | Continuous Home Care Full Rate = 24 hours of care (\$56.80 = hourly rate). | \$1,363.26 | × 1.0041 | × 1.007 | \$1,378.43 |
| 655 | Inpatient Respite Care | 435.82 | × 1.0049 | × 1.007 | 441.02 |
| 656 | General Inpatient Care | 994.45 | × 1.0060 | × 1.007 | 1,007.42 |

* Transition from FY 2019 Wage Index to FY 2020 Wage Index without 1-Year Lag.

6. Proposed Hospice Cap Amount for FY 2020

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (Pub. L. 113–185). Specifically, for accounting years that end after September 30, 2016, and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. The proposed hospice cap amount for the FY 2020 cap year will be \$29,993.99, which is equal to the FY 2019 cap amount (\$29,205.44) updated by the proposed FY 2020 hospice payment update percentage of 2.7 percent.

C. Proposed Election Statement Content Modifications and Proposed Addendum To Provide Greater Coverage Transparency and Safeguard Patient Rights

1. Background

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of an individual may necessitate a transition from curative to palliative care if the individual so chooses. Medicare hospice care services are virtually all-inclusive, and are focused on meeting the

physical, emotional, psychosocial and spiritual needs of the terminally ill individual and his or her family. In order to make an informed choice about whether to receive hospice care, the patient, family, and caregiver must have an understanding of what services are going to be provided by the hospice and that, because there is no longer a reasonable expectation for a cure, care should now focus on comfort and quality of life. The services covered under the Medicare hospice benefit are comprehensive such that, upon election, the individual waives all rights to Medicare payment for services related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made, except when provided by the designated hospice or attending physician. Because of the significance of this decision, the terminally ill individual must elect hospice care in order to receive services under the Medicare hospice benefit. Since we first implemented the Medicare hospice benefit in 1983, it has been our general view that the waiver required by law requires hospices to provide virtually all the care that is needed by terminally ill patients (48 FR 56010).

2. Current Statutory and Regulatory Requirements for Care Planning and Patient Rights

In order to be eligible to elect the Medicare hospice benefit, a beneficiary must be certified as terminally ill, meaning that the beneficiary has a medical prognosis of a life expectancy of 6 months or less if the illness runs its normal course (42 CFR 418.3). For the initial certification, the patient-designated attending physician (if any) and the hospice medical director (or hospice physician member of the interdisciplinary group (IDG)) must each certify in writing, at the beginning of the period, that the individual is terminally ill based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. The regulations § 418.25 require that the hospice admit a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).

In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider the principal diagnosis of the patient, all other health conditions, whether related or unrelated to the terminal condition, and all clinically relevant information

supporting all diagnoses. The clinical information and other documentation that support the medical prognosis must accompany the written certification and must be filed in the individuals' hospice medical record in accordance with the regulations at § 418.22(b)(2). Likewise, for the initial certification of terminal illness, the hospice CoPs at § 418.102(b) require that the hospice medical director (or hospice physician designee) consider not only the principal diagnosis and related conditions, but also current signs and symptoms affecting the patient, current medications and treatment interventions, and the medical management of unrelated conditions. Therefore, even prior to a patient's admission to hospice, the hospice medical director (or hospice physician designee) plays a pivotal role in making clinical determinations regarding related and unrelated conditions of terminally ill individuals. Once a beneficiary is certified as terminally ill, he or she becomes eligible to elect hospice care under the Medicare hospice benefit.

Because the receipt of hospice services under the Medicare hospice benefit is dependent upon the eligible beneficiary electing to receive hospice care, the regulations at § 418.24 provide the requirements of the hospice election statement. The election statement must include the identification of the designated hospice and attending physician (if any); the individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care; and the individual's or representative's acknowledgement that the individual waives the right to Medicare payment for services related to the terminal illness and related conditions, except when provided by the designated hospice or attending physician. Services unrelated to the terminal illness and related conditions remain eligible for Medicare coverage and payment outside of the hospice benefit.

Once the beneficiary has elected hospice care, the hospice conducts an initial assessment visit in advance of furnishing care. During this visit, the hospice must provide the patient or representative with a spoken and written notice of the patient's rights and responsibilities as required by the CoPs at § 418.52. Our rules state that the beneficiary has the right to be involved in developing his or her hospice plan of care; receive information about the services covered under the hospice benefit; and receive information about the scope of services that the hospice

will provide and specific limitations on those services. The hospice program must assure the patient that its staff will protect patients' rights and will involve patients in decisions about their care, treatment and services.³³ Likewise, the regulations at § 476.78 state that providers must inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to Quality Improvement Organization (QIO) review. CMS identifies the core functions of the QIO Program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints.

Changes to the QIO Program were made to ensure that Medicare beneficiary needs are better met by designating a special type of organization, a Medicare Beneficiary and Family—Centered Care—Quality Improvement Organization (BFCC-QIO), to address quality of care concerns and appeals. When Medicare beneficiaries have a complaint that is not related to the clinical quality of healthcare, they and their healthcare provider can agree to participate in a flexible, dialogue-based resolution process, called “immediate advocacy,” which is coordinated by the BFCC-QIO (§ 476.110).

The patient rights are provided to the beneficiary at the beginning of a hospice election. Likewise, the hospice CoPs at § 418.54 require that the hospice registered nurse must complete the initial assessment within 48 hours after the election of hospice care, unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours. The initial assessment is to gather critical information necessary to treat the patient/family's immediate care needs. The hospice IDG, in consultation with the individual's attending physician (if any), must complete a comprehensive assessment no later than 5 calendar days after the election of hospice care. Additionally, the hospice CoPs at § 418.54(c) provide the content requirements for the initial and comprehensive assessments used to

identify patient, family, and caregiver needs for physical, emotional, psychosocial, and spiritual care. As part of the comprehensive assessment, the hospice is required to assess the patient for complications and risk factors, which can affect care planning. The needs identified in these assessments drive the development and revisions of an individualized written plan of care for each patient as required by the CoPs at § 418.56. Collectively, the IDG, in consultation with the patient's attending physician (if any), makes care plan decisions for each patient to ensure that each care plan is individualized to meet the unique needs of each hospice beneficiary. The plan of care also must reflect patient, family, and caregiver preferences, goals, and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions and the CoPs at § 418.56(c) detail the plan of care content requirements, including the following:

(1) Interventions to manage pain and symptoms.

(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.

(4) Drugs and treatment necessary to meet the needs of the patient.

(5) Medical supplies and appliances necessary to meet the needs of the patient.

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record. Furthermore, as a condition for payment, the services provided must be consistent with the plan of care (§ 418.200).

Though hospices are responsible for providing all services needed for palliation and management of the terminal illness and related conditions, the 2008 Hospice Conditions of Participation final rule (73 FR 32088, June 5, 2008) states that while needs unrelated to the terminal illness and related conditions are not the responsibility of the hospice, the hospice may choose to furnish services for those needs regardless of responsibility (73 FR 32114). If a hospice does not choose to furnish services for those needs unrelated to the terminal illness and related conditions,

³³ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf.

the hospice is to document such needs and communicate and coordinate with those health care providers who are identified as caring for the unrelated needs, as set out at § 418.56(e)(5). In the 2008 final rule, we stressed that the intent of the plan of care requirements are to show a direct link between the needs identified in the comprehensive assessment and the plan of care developed by the hospice. This also means that even if the hospice identified other needs in the patient assessment that were unrelated to the terminal illness and related conditions, these needs could not simply be ignored by the hospice; rather, the hospice would have to communicate and coordinate with the non-hospice providers that would be managing those conditions (73 FR 32114).

To ensure comprehensive and coordinated care, at § 418.56(e) we require hospices to have a communication system that allows for the exchange of information with other non-hospice health care providers who are furnishing care unrelated to the terminal illness and related conditions. We also require hospices to designate a registered nurse (RN) who is a member of the IDG to coordinate implementation of the comprehensive plan of care. The designated RN must assure that coordination of care and continuous assessment of patient, family, and caregiver needs occur among staff providing services to the patient, family, and caregiver so that all IDG members are kept informed of the patient/family's status.³⁴ The goal of a coordinated communication process and a designated nurse coordinator is to adequately ensure that each patient's hospice care is coordinated both within the hospice and with other health care providers.

3. Services Unrelated to the Terminal Illness and Related Conditions

As discussed in section III.C.2., the hospice medical director, the attending physician (if any), and the hospice IDG determine, for each patient, what items and services are related and unrelated to the palliation and management of the terminal illness and related conditions during the admission process, the initial and comprehensive assessments, and in the development of the hospice plan of care. To the extent that individuals receive services outside of the Medicare hospice benefit during a hospice election, Medicare coverage is determined by whether or not the

services are for the treatment of a condition completely unrelated to the individual's terminal illness and related conditions (48 FR 38146, 38148, August 22, 1983). As such, it is our long-standing position that services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit (48 FR 56008, 56010, December 16, 1983). The Medicare claims processing system has edits in place to prevent other non-hospice claims from being processed while a patient is under a hospice election. For claims unrelated to the terminal illness and related conditions to be processed for Medicare payment while a patient is under a hospice election, the non-hospice provider or supplier must use a modifier or condition code on the claim to indicate that the service billed is unrelated to the patient's terminal condition. This is to help ensure that payment is made from the appropriate Medicare trust fund, and that duplicate payments are avoided.

In accordance with the hospice CoPs at § 418.56(e)(5), and in alignment with continuity of care principles,³⁵ the ongoing sharing of information with other non-hospice healthcare providers and suppliers furnishing services unrelated to the terminal illness and related conditions is necessary to ensure coordination of services and to meet the patient, family, and caregiver needs. The coordination requirements include that the hospice must develop and maintain a system of communication and integration amongst all providers furnishing care to the terminally ill patient. This communication helps to minimize fragmented care and to improve quality of life. Part of that communication process is the clear identification of what the related and unrelated conditions are and who is responsible for providing reasonable and necessary services for those conditions. As is the preferred practice for care coordination and communication,³⁶ both hospice and non-hospice providers typically document these discussions, which then becomes part of the patient's medical record with each provider. Accordingly, all Medicare providers and suppliers

must be able to provide medical documentation to support payment for services billed (sections 1833(e) and 1815(a) of the Act). For non-hospice providers or suppliers billing Medicare for services received by hospice beneficiaries unrelated to their terminal illness and related conditions, this includes being able to provide documentation from the hospice listing the conditions (and thus items, drugs, and services) the hospice determined to be unrelated and documented as such on the hospice plan of care.

While hospices are required by the CoPs to have a system of communication with non-hospice providers to furnish such information, we have heard anecdotally from non-hospice providers stating that they are unable to reach or do not receive return calls from the hospice to discuss the hospice beneficiary's coordination of services that the hospice has determined unrelated to his or her terminal illness and related condition(s). Likewise, we have also received anecdotal reports from hospices who state they were unaware that patients had received care from non-hospice providers. In these reports, the hospice would first learn of this outside care when non-hospice providers would contact the hospice seeking reimbursement. If this care was related to the terminal illness and related conditions and the hospice did not make arrangements for such care, the beneficiary would be liable for the costs of receiving that care. Additionally, if non-hospice providers bill Medicare for services that potentially should have been the coverage responsibility of hospice, Medicare could be making duplicative payments for care related to the terminal illness and related conditions.

The OIG released a report in June of 2012 identifying situations where Medicare may have been paying twice for prescription drugs for hospice beneficiaries. This report also suggests that Medicare hospice beneficiaries themselves could also be paying unnecessary co-payments or coinsurance for prescription drugs.³⁷ In addition to being liable for unnecessary co-payments or coinsurance, if beneficiaries fill prescriptions to treat conditions that are related to the terminal illness and related conditions without such fills being arranged for by the hospice, the patient would be liable for the entire cost of the prescription.

³⁵ Uijena, A., Schersa, H., Schellevis, F., van den Bosch, W. How unique is continuity of care? A review of continuity and related concepts. *Family Practice* 2012; 29:264–271 doi:10.1093/fampra/cmr104.

³⁶ National Quality Forum (NQF), Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report, Washington, DC: NQF; 2010.

³⁷ Office of the Inspector General, Department of Health and Human Services. Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice. June, 2012. A–06–10–00059. <https://oig.hhs.gov/oas/reports/region6/61000059.pdf>.

³⁴ https://www.cms.gov/RegulationsandGuidance/Manuals/downloads/som107ap_hospice.pdf.

The OIG identified four common categories of prescription drugs that are typically used to treat end-of-life symptoms that were being covered under Part D for beneficiaries under a hospice election. These four categories of drugs included analgesics, anti-nauseants, laxatives, and anti-anxiety agents. As a result of this report, CMS issued the first of several memoranda seeking to clarify the criteria for determining payment responsibility under the Part A hospice benefit and Part D for drugs prescribed to hospice beneficiaries. Part D plan sponsors were encouraged to place beneficiary-level prior authorization (PA) requirements on drugs being processed through Part D for hospice beneficiaries. The purpose of this PA form is to facilitate coordination between Part D sponsors, hospices, and pharmacists. Two primary uses are to document that a drug is unrelated to a beneficiary's terminal prognosis and to convey a beneficiary's change in hospice status. It may also be used by hospice providers to communicate and update the medication list from the beneficiary's plan of care.³⁸ In 2014, when the PA was instituted for all beneficiaries enrolled in hospice, utilization was reduced for both drugs in and outside of the four categories. However, when the PA was lifted for drugs not in the four categories (that is, maintenance drugs) there have been steady increases in utilization of these drugs by hospice beneficiaries through Part D.³⁹ Recent analyses of Part D prescription drug event (PDE) data suggest that the current PA process has reduced Part D program payments for drugs in the four targeted categories and that utilization patterns are sensitive to the PA process.⁴⁰

After a hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, there are maintenance drugs that are appropriate to continue as they may offer symptom relief for the palliation and management of the terminal illness and related conditions. Some examples of maintenance drugs include those to manage conditions such as heart disease, COPD, and diabetes. We continue to receive complaints from Part D plan sponsors

and pharmacies that some hospice providers fail to respond to frequent outreach efforts from Part D sponsors seeking recovery for claims in the four categories or to clarify payment responsibility for medications for hospice beneficiaries. We believe that this represents a lack of coordination between hospices and Part D pharmacies and sponsors, which ultimately affects the quality of care furnished to an especially vulnerable population and results in additional costs to beneficiaries, as well as Part D plan sponsors.

In previous years' hospice proposed rules, we have included data on non-hospice expenditures for beneficiaries under a hospice election. These total non-hospice expenditures include beneficiary cost-sharing amounts. For Parts A and B, the beneficiary cost-sharing amounts in FY 2017 totaled approximately \$138 million and for Part D, the beneficiary cost-sharing totaled approximately \$68.6 million (83 FR 20946 through 20947). We believe that this is a substantial financial burden being placed on terminally ill individuals for services that potentially should have been covered by hospice. In previous years' rules, we have provided data and case studies on the most frequently reported principal diagnoses on hospice claims and their associated non-hospice expenditures for what were determined to be services for unrelated conditions (80 FR 47154 and 81 FR 25510). These diagnoses included lung cancer, cerebral degeneration of the brain (that is, conditions that cause dementia), chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). We also discussed the recommended evidence-based clinical practice guidelines for those diagnoses, including the use of certain types of DME, supplies and drugs. Our analysis revealed that items such as oxygen, respiratory agents, hospital beds, wheelchairs, common palliative drugs, and disease-specific drugs were not being furnished or covered by hospice even though we would expect such items to be clinically indicated and provided for the palliation and management of the terminal illness and related conditions (80 FR 47154). This suggests that hospice beneficiaries may be incurring unnecessary financial burden as they are having to seek out and pay for items and services for pain and symptom relief—services that hospice should be furnishing and covering.

We have received numerous anecdotal reports from beneficiaries, families, and non-hospice providers that hospice patients are obtaining needed

drugs and other services outside of the hospice benefit because they have been told that hospice would not cover the drugs as the hospice determined that they were unrelated to the terminal illness and related conditions. Many of these anecdotal reports state that the beneficiaries and families believe that these items, services, and drugs were related to the terminal illness and related conditions and believed that they should have been provided by the hospice. The beneficiaries and/or the families stated that they did not know they would have to seek care outside of the hospice benefit for these conditions because the hospice did not tell them these items, services, and drugs would not be furnished by the hospice until the patient needed them. The Medicare Beneficiary Ombudsman Office also has received similar reports. The Medicare Ombudsman helps beneficiaries with Medicare-related complaints, grievances, and information requests, regarding what beneficiaries need to know to make appropriate health care decisions; beneficiary rights and protections under Medicare; and how to get issues resolved.⁴¹ Whereas the Medicare Ombudsman helps with providing general information about Medicare and navigating through various Medicare processes to resolve issues, the BFCC-QIOs assist Medicare beneficiaries with specific quality of care complaints for people with Medicare to improve the effectiveness, efficiency, economy, and quality of services for people with Medicare. The BFCC-QIOs provide services to help Medicare beneficiaries file appeals if they think their coverage is ending too soon; to conduct quality of care and medical necessity reviews, and; to help with grievances. Both entities are in place to make sure beneficiary rights are protected.

The Medicare Ombudsman also shares information with the Secretary of Health and Human Services, Congress, and other organizations about what does and doesn't work well to improve the quality of the services and care beneficiaries get through Medicare. Examples of recent Medicare Ombudsman reports of patients being told only after electing the benefit and the commencement of hospice care that certain items, services or drugs were not covered by the hospice include:

- An incident was reported to the Medicare Beneficiary Ombudsman Office by a hospice beneficiary who stated that when she ran out of her

³⁸ <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Instruction-and-Form-for-Hospice-and-Medicare-Part-D.pdf>.

³⁹ The four categories of drugs listed above are not included in the analyses of maintenance drugs.

⁴⁰ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf>.

⁴¹ <https://www.cms.gov/Center/Special-Topic/Ombudsman/How-the-Medicare-Beneficiary-Ombudsman-Works-for-You.pdf>.

diabetic test strips, the hospice refused to furnish them. The patient stated that the diabetic glucose testing was necessary to ensure the appropriate dosage of medication to control her blood glucose level, and hence prevent any symptoms that would be associated with hyperglycemia. When contacted, the hospice informed the Ombudsman that the hospice determined the patient's diabetes was not related to the patient's principal diagnosis of congestive heart failure (CHF) and thus the hospice was not furnishing any services to manage the patient's diabetes. While this hospice told the patient that her diabetes was unrelated to her congestive heart failure, they did not do so until after the beneficiary elected hospice and ran out of her test strips. The beneficiary disagreed with that determination but was not made aware of options for advocacy to assist in resolving this disagreement with the plan of care. Because of this lack of communication, the beneficiary felt she had no choice but to obtain her test strips and pay for them herself.

- A family member contacted CMS on behalf of his mother and stated that the hospice refused to furnish a seated walker because the hospice had determined the need for a seated walker was unrelated to the beneficiary's terminal illness and related conditions. This beneficiary was unable to ambulate without having to stop and sit down because of shortness of breath due to her end-stage lung cancer. The family member mentioned that his father was going to purchase the walker out of pocket, but he wanted to check with Medicare before doing so. The beneficiary was very distressed because being able to ambulate in her own home lessened the pain of lying in bed for prolonged periods of time and improved the quality of her life. The family member stated he did not know whom to call because he was under the impression that hospice was to cover everything his mother needed.

- During a CMS field office site visit, one hospice beneficiary reported that the hospice would not cover the cost of his benign prostatic hypertrophy (BPH) medication as the hospice stated the medication was unrelated to his terminal illness and related conditions. This medication helped alleviate urinary retention which caused him significant discomfort. This beneficiary had a hospice-reported principal diagnosis of sepsis due to a urinary tract infection. The beneficiary obtained his BPH medication through his pharmacy benefit but he stated he thought hospice was to provide him with all of his medications because that was the

impression the hospice had given him when he elected hospice. He said he was never told by the hospice what medications or services he would have to obtain on his own.

- CMS has received multiple reports of hospice beneficiaries requiring palliative chemotherapy or palliative radiation for pain and symptom management, but these beneficiaries are told by hospices that these services are not covered under the hospice benefit because these treatments are curative in nature and therefore not in alignment with the hospice philosophy of care. These beneficiaries report that they were not told this when they elected hospice and they revoked the hospice benefit in order to receive needed treatments to alleviate pain.

- Similarly, CMS has met with physician associations to discuss the Medicare hospice benefit and physicians report that when they try to refer patients to hospice who require palliative blood transfusions for symptom management, the physicians and their patients are being told by hospices that the Medicare hospice benefit does not cover palliative blood transfusions. The physicians reported that they either do not refer these patients to hospice to ensure that the patients can continue their palliative blood transfusions, or for those patients that do elect the hospice benefit, those patients revoke hospice care to receive their palliative blood transfusions and then re-elect hospice care after they have received these services. We note that the Medicare hospice benefit does cover services for pain and symptom management, including palliative chemotherapy, radiation and blood transfusions. The per diem payment amounts paid to hospices account for such services and hospices are required to cover those items, services, and drugs for the palliation and management of the terminal illness and related conditions.

The continued anecdotal reports we receive from various stakeholders may suggest that some hospices are not adequately informing hospice patients at hospice election about the scope of services covered under the hospice benefit and thus hospice patients may not have complete benefit coverage information when electing the hospice benefit. This lack of coverage transparency may result in hospice patients having to seek out needed items, services and drugs outside of the Medicare hospice benefit and incur unexpected financial liability as a result. This also may suggest that hospices could be making care plan decisions based on cost or convenience

rather than based on the needs, preferences and goals of the patient. This is not in alignment with the Medicare hospice benefit regulations and CoPs. We expect that services received outside of the hospice benefit to be rare.

Since the implementation of the Medicare hospice benefit, we have received frequent requests, via informal means and through the formal rulemaking process to provide additional guidance about determining what are considered "related conditions" as these are the coverage responsibility of hospice. Our position has been the same since the implementation of the Medicare hospice benefit in 1983. We believe that hospices are required to provide virtually all of the care needed by the terminally ill individual (48 FR 56010). Any services needed outside of the hospice benefit (that is, "unrelated") should be exceptional and unusual. We reiterate that the terminally ill individual's unique clinical condition makes it necessary for these determinations of related versus unrelated conditions to be made for each patient. To be responsive to the numerous requests for more guidance, in recent years' rules we have provided additional guidance regarding eligibility requirements for hospice admission (79 FR 50470 and 80 FR 25878); assessment of other conditions and comorbidities (80 FR 25878 through 25879); and, reporting of related and unrelated conditions on hospice claims (80 FR 25880). However, in spite of the guidance provided, we continue to have concerns that these decisions are based on a more narrow view of the overall condition of the individual, as is evidenced by the non-trivial amount of items, services, and drugs for potentially related conditions provided by non-hospice providers to beneficiaries under a hospice election.

4. Proposed Election Statement Content Modifications and Proposed Addendum To Provide Greater Coverage Transparency and Safeguard Patient Rights

As mentioned previously, the CoPs at § 418.56 require that the hospice include all services needed for the palliation and management of the terminal illness and related conditions on the individualized hospice plan of care. Similarly, the hospice interpretative guidelines for § 418.56 state that the plan of care should also identify the conditions or symptoms that the hospice determines to be "unrelated" so hospices can provide ongoing sharing of information with

other non-hospice healthcare providers who may be furnishing services unrelated to the terminal illness and related conditions.⁴² Although hospices are required to educate each patient and the primary caregiver(s) on the services identified on the plan of care and document the patient's or representative's level of understanding, involvement, and agreement with the plan of care, the amount and nature of the non-hospice services being billed to Medicare outside of the hospice benefit suggests that hospice beneficiaries may not be fully informed, at the time of admission or throughout the hospice election, of the items, services, and drugs the hospice has determined to be unrelated to their terminal illness and related conditions. This is necessary information for patients and their families to make informed care decisions and to anticipate any financial liability associated with needed items, services, and drugs not provided under the Medicare hospice benefit.

The Medicare hospice regulations and CoPs are designed to ensure comprehensive coverage of hospice services and to help educate patients and their families regarding the scope of hospice services. Patient protection, empowerment, and advocacy are of such utmost importance that the CoPs at § 418.52 explicitly require that the hospice inform the patient of his or her rights and promote the exercise of these rights. However, as described in section III.C.3 above, we have concerns about whether patients are being adequately informed about the scope of services covered under the Medicare hospice benefit and whether patient rights are being fully promoted and protected. Furthermore, we continue to be concerned about the currently reported poor or absent communication between hospice and non-hospice providers needed to ensure coordination of all reasonable and necessary services for Medicare hospice beneficiaries. This may result in a lack of coverage transparency and where beneficiaries are unaware of their financial liability while under a hospice election for those items, services, and drugs the hospice has determined to be unrelated to their terminal prognosis.

Patients and their families must be provided complete and accurate information regarding their hospice benefit under Medicare, as well as their rights, responsibilities, and financial liability to ensure that they are empowered to make informed treatment

decisions that align with their personal needs, preferences, and goals. In order to receive services under the Medicare hospice benefit, the beneficiary must make a choice to elect the benefit. As with all medical choices, this would mean that the beneficiary (or representative) has given informed consent for services. Stated simply, informed consent in medical care, which includes hospice care, is a process of communication between a clinician and a patient that results in the patient's authorization or agreement to undergo a specific medical intervention or mode of care.⁴³

Therefore, we are proposing to modify the hospice election statement content requirements at § 418.24(b) to increase coverage transparency for patients under a hospice election. In addition to the existing election statement content requirements at § 418.24(b), we are proposing that hospices also would be required to include the following on the election statement:

- Information about the holistic, comprehensive nature of the Medicare hospice benefit;
- A statement that, although it would be rare, there could be some necessary items, drugs, or services that will not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.
- Information about beneficiary cost-sharing for hospice services.
- Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice's determination.

Likewise, we are proposing to make the corresponding regulations text changes at § 418.24(b).

Additionally, we are proposing that hospices would be required, upon request, to provide to the beneficiary (or representative) an election statement addendum with a list and rationale for the conditions, items, services, and drugs that the hospice has determined as unrelated to the terminal illness and related conditions. Similarly, we are proposing that hospices would be required to provide the election

statement addendum upon request to other non-hospice providers that are treating such conditions, and Medicare contractors who request such information. We are proposing that if the election statement addendum is requested at the time of hospice election, the hospice must provide this information, in writing, to the individual (or representative) within 48 hours of the request. Furthermore, we are proposing that if this addendum is requested during the course of hospice care, the hospice must provide this information, in writing, immediately to the requesting individual (or representative), non-hospice provider, or Medicare contractor, as this information should be readily available in the beneficiary's hospice medical record. While we believe that hospices should be able to immediately provide this information, in writing, to the requesting beneficiary (or representative), non-hospice provider or Medicare contractor, we are soliciting comment on the appropriate timeframe to provide this information to the requesting party if such information is requested after the election of hospice care. During the course of hospice care, if there are changes to the plan of care that result in a determination that a new illness or condition has arisen, we are proposing that hospices would be required to issue an updated addendum to the patient (or representative) reflecting whether or not items, services and supplies related to the new illness or condition will be provided by the hospice.

The purpose of the proposed addendum is to inform beneficiaries and their families of non-covered conditions, items, services, and drugs to provide full coverage transparency to hospice patients and their families to assist in making treatment decisions. Likewise, the addendum will help facilitate communication and benefit coordination between hospices and non-hospice providers. We propose that if there is a request for the addendum, the presence of the signed addendum (and updated, signed addenda) in the beneficiary's hospice medical record would be a new condition for payment for Medicare hospice services.

Hospices can develop and design the addendum to meet their needs, similar to how hospices develop their own hospice election statement. We propose the addendum would be titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs." We propose that the addendum would include the following information:

1. Name of the hospice;

⁴² https://www.cms.gov/Regulations-and-Guidance/Manuals/downloads/som107ap_m_hospice.pdf (L-Tag 538).

⁴³ https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_Twenty-One_February_2016.pdf.

2. Beneficiary's name and hospice medical record identifier;
3. Identification of the beneficiary's terminal illness and related conditions;
4. A list of the beneficiary's current diagnoses/conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs, not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions;
5. A written clinical explanation, in language the beneficiary and his or her representative can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation would be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs is related is made for each patient and that the beneficiary should share this clinical explanation with other health care providers from which they seek services unrelated to their terminal illness and related conditions;
6. References to any relevant clinical practice, policy, or coverage guidelines.
7. Information on the following domains:

a. Purpose of Addendum

- i. The purpose of the addendum is to notify the hospice beneficiary (or representative) of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the beneficiary's terminal illness and related conditions.
- ii. The addendum is subject to review and shall be updated, as needed, when the plan of care is updated in accordance with § 418.56. The hospice will provide these updates, in writing, to the beneficiary (or representative).

b. Right to Immediate Advocacy

The addendum must include language that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice's determination. Specifically, the language must include contact information for the BFCC-QIO, as well as, the following statement: "*We encourage you to contact your hospice provider to discuss any concerns about the diagnoses/conditions, as well as items, services, and medications listed on this form that you believe should be covered by the hospice. Beyond issues related to Medicare coverage, if you believe that your care concerns were not*

adequately addressed by your hospice provider, you may contact the Medicare Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) to help you. While it cannot require services be covered, provided, or be paid for by Medicare, the BFCC-QIO addresses quality of care issues for people with Medicare. There are various ways the BFCC-QIO can assist you: (a) verbally engaging providers on your behalf to seek quick resolution, known as Immediate Advocacy, or (b) by having an independent physician review of your medical documentation to determine if there was a quality issue."

8. Name and signature of Medicare hospice beneficiary (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the beneficiary's agreement with the hospice's determinations.

Finally, we are proposing to add the election statement addendum content requirements to the regulations at § 418.24.

As discussed and proposed above, the signed addendum (and any signed updates) would be a new condition for payment. This does not mean that in order to meet this condition for payment that the beneficiary (or representative), or non-hospice provider must agree with the hospice's determination. For purposes of this condition for payment, the signed addendum is only acknowledgement of the beneficiary's (or representative's) receipt of the addendum (or its updates) and this payment requirement would be met if there was a signed addendum (and any signed updates) in the requesting beneficiary's medical record with the hospice. This addendum would not be required to be submitted with any hospice claims. Likewise, the hospice beneficiary (or representative) would not have to separately consent to the release of this information to non-hospice providers furnishing services for unrelated conditions as the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's express authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different

patient, or to refer the patient (45 CFR 164.506).

This hospice election statement addendum would only be required for Medicare hospice beneficiaries who request such information, though hospices may choose to provide this addendum to all of their hospice patients, regardless of payer source (after making appropriate adjustments for the specific payer). Hospices can determine which member of the IDG would be responsible for completing this addendum, but we would expect that this typically would be the function of the hospice registered nurse responsible for the patient's plan of care. As mentioned previously, hospices must designate a registered nurse (RN), who is a member of the IDG, to coordinate implementation of the comprehensive plan of care. The designated RN must assure that coordination of care and continuous assessment of patient, family, and caregiver needs occur among staff providing services to the patient, family, and caregiver so that all IDG members are kept informed of the patient/family/caregiver's status (§ 418.56(a)).

While ideally this addendum would be provided to the requesting beneficiary (or representative) at the time of hospice election, we recognize that hospices may need some leeway to have discussion amongst the members of the IDG to finish developing the hospice plan of care. Therefore, we are proposing that the addendum would be required to be provided to the requesting beneficiary (or representative) within 48 hours of the hospice election date; and the beneficiary would sign the addendum and receive a completed, signed copy at that time for his/her records. This is in alignment with the current CoP requirements at § 418.54(a) stating that the hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care. Hospices would be exempt from completing this addendum if the beneficiary died within 48 hours of the election date of hospice care. The original beneficiary or representative-signed election statement and addendum would be included in the patient's hospice medical record as already required by the hospice CoPs at § 418.104(a)(2).

If the beneficiary (or representative) requests this addendum after admission to hospice, we are proposing that the hospice would provide the addendum immediately to the beneficiary (or representative), as this information should already be readily available in the beneficiary's hospice medical

record. Additionally, we are proposing that hospices would be required, upon request, to provide a copy of the addendum (with the list of non-covered items, services and drugs) to non-hospice providers rendering services to the hospice beneficiary to support the hospice's determination that those items, services, or drugs are for unrelated conditions. Likewise, if there are any changes to the conditions, items, services, and/or drugs listed on the addendum that occur after the hospice election and during the course of hospice care, the hospice would update the addendum accordingly and the beneficiary would sign and date any updates to acknowledge that he/she has received the information. This would occur for both additions to and removal of any unrelated conditions, items, services, and/or drugs. However, we do not expect that additions to addendum would be a frequent occurrence. Body systems are interrelated and as an individual progresses closer to death, all care is related to the dying process and thus we would not expect to see unrelated conditions, items, services, or drugs routinely added to the addendum.

While the proposed election statement addendum outlines the content requirements for the addendum, it does not mandate the use of a specific form. Hospices are able to design the addendum in the form or format that best meets their needs, assuming all content requirements are met. As there is currently a model election statement available in a MLN Matters® article, SE1631,⁴⁴ we also will assist hospices in developing the addendum. If finalized, we would post a model election statement with the added content requirements, as well as a model addendum on the Hospice Center web page to help hospices in developing their addendums and thereby minimizing their costs.

Furthermore, Part D plan sponsors currently have a prior authorization process in place for their member enrolled in hospice for the four categories of drugs (analgesics, anti-nausea, anti-anxiety, and laxatives) and a voluntary, standardized form was developed with industry input for hospices to submit to Part D plans in order to assist in: (1) Proactively avoiding a drug claim from rejecting at point-of-sale; (2) overriding a reject edit at point-of-sale; and (3) communicating a change in the a patient's hospice

status.⁴⁵ Hospices currently can use the standardized PA form as a means of notifying a Part D plan that their member has elected hospice care, as well as to document specific drugs that are or are not being covered by the hospice. As such, we intend to work with hospices and Part D plans to develop a process in which the "Patient Notification of Hospice Non-covered Items, Services and Drugs" potentially could be used at the point-of-service when hospice beneficiaries are filling drug prescriptions to ensure timely access to needed drugs. Complete documentation on the part of the hospice, coupled with timely notification of Part D sponsors, mitigates the risk for possible double payment by the Medicare program for drugs, and is anticipated to prevent Part D enrollees in hospice from having a hospice-related medication billed by a pharmacy to their Part D plan, potentially subjecting the beneficiary to out-of-pocket expenses.

While the CoPs already require that information on unrelated conditions should be documented and communicated to beneficiaries and non-hospice providers (§ 418.56), we believe that making this a condition for payment will help to ensure that hospices are diligent in providing this information to Medicare hospice beneficiaries. It is important to note that the proposed modifications to the hospice election statement and the election statement addendum, "Patient Notification of Hospice Non-Covered Items, Services, and Drugs," leverages existing hospice regulations, CoPs, and QIO requirements for hospices to:

- Identify those conditions and services present on hospice admission (and at plan of care update, as necessary) that the hospice has determined to be unrelated to the terminal illness and related conditions (§§ 418.22, 418.54(c)(2), 418.102), as outlined in element 4 of the addendum as noted above;
- Inform the beneficiary and family about what is covered and not covered by the hospice on the plan of care (§§ 418.52 and 418.56(b)), as outlined in the proposed additional election statement content requirements and elements 3, 4, 5, and 6 of the addendum as noted above;
- Coordinate with providers that are providing care unrelated to the terminal illness and related conditions (§ 418.56(e)(5)), as outlined in the proposed, additional election statement content requirements and elements 4, 5,

and 6 of the addendum as noted above; Educate beneficiaries about their patient rights (§§ 418.52(a) and 476.78(b)(3)), as outlined in the proposed, additional election statement content requirements and element 7 of the addendum as noted above.

We believe that the election statement addendum will promote greater transparency regarding coverage under the Medicare hospice benefit, as well as informing the beneficiary as to those services they might need to seek outside of the hospice benefit. This would help in beneficiary decision-making regarding needed items, services, and drugs, and to determine the model of care that best meets their treatment preferences and goals of care. Likewise, we believe the addendum would provide information that would allow hospice beneficiaries to anticipate potential financial liability for health care services outside of the hospice benefit. Because hospices would have to provide a list and clinical rationale for those items, services, and drugs that they will not be covering because the hospice has determined them to be unrelated to the terminal illness and related conditions, to requesting hospice beneficiaries (or representatives), non-hospice providers rendering services to hospice beneficiaries, and/or Medicare contractors, we believe this accountability may mitigate unnecessary financial burden for hospice beneficiaries. A primary goal of the election statement addendum is to hold hospices more accountable to hospice beneficiaries through benefit coverage transparency. Hospices should already be holistic and comprehensive in their approach to the provision of hospice services. We believe this proposal would be an incremental step in ensuring beneficiaries are receiving information regarding the full scope of Medicare hospice benefits. Subsequently, if the proposed addendum is finalized, we would continue to monitor hospice utilization trends, including non-hospice spending, to determine whether any additional changes may be warranted.

As the hospice regulations and the CoPs already require the assessment and documentation of unrelated conditions as described throughout this section, we believe there is no increase in hospice burden resulting from this addendum requirement to communicate with non-hospice providers. Similarly, we believe the collection of information for the election statement and the addendum is already accounted for in the hospice CoP burden estimates in its information collection request (OMB control number: 0938-1067) that was re-

⁴⁴ <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1631.pdf>.

⁴⁵ Hospice Information for Medicare Part D Plans, OMB-approved form (No. 0938-1269).

approved in November, 2017.⁴⁶ However, we estimate a one-time hospice cost burden to develop the election statement addendum, as well as a small increase in the time spent to complete the addendum. This estimate is described in section IV of this proposed rule. We believe that this election statement addendum would serve to streamline existing regulatory requirements into a single tool for communicating with beneficiaries and their families, the beneficiary's designated independent attending physician (if any), as well as, with non-hospice providers furnishing items, services, and drugs to hospice beneficiaries. As the addendum should also be used to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions, as required by the CoPs, it would likely minimize time spent by IDG members looking through a beneficiary's medical record to locate the information on unrelated conditions, items, services, and drugs when such information is requested by non-hospice providers.

Furthermore, this addendum, if filled out completely, updated regularly, and shared proactively and in a timely manner with non-hospice providers and pharmacies, would minimize multiple calls from non-hospice providers and pharmacies to the hospice requesting information on a patient's unrelated conditions, items, services, and drugs since the addendum would provide this comprehensive information in a practical, consistent, and useful format. In effect, this addendum would reduce burden for non-hospice providers because this addendum could assist in making treatment decisions and support the coding of an appropriate modifier or condition code on non-hospice claims for services unrelated to the terminal illness and related conditions. Non-hospice providers providing services to hospice beneficiaries are required to report the following on Medicare claims to identify that the items or services were for the treatment of conditions unrelated to the terminal illness and related conditions:

- Institutional providers would submit a claim with condition code 07.
- Physicians would submit a claim with modifier GW.

The election statement addendum may allow the non-hospice provider to be "without fault" if there is any question regarding an overpayment. In accordance with section 1870 of the Act,

a provider is responsible for an overpayment if the provider knew or had reason to know that service(s) were not reasonable and necessary, and/or the provider did not follow correct procedures or use care in billing or receiving payment. If non-hospice providers have the addendum, this potentially could satisfy section 1870 of the Act in providing that the non-hospice provider did not have reason to know that the services were not reasonable and necessary (considering the service itself is reasonable and necessary and satisfies all other requirements for payment). Moreover, if a non-hospice provider submits a claim to Medicare for services provided to a beneficiary that are unrelated to the terminal illness and related conditions but does not have the supporting documentation that the services are unrelated, this could be considered a false claim under the False Claims Act.⁴⁷ Having the addendum identifying the unrelated conditions, items, services, and drugs may provide the necessary documentation support that the non-hospice provider was rendering services unrelated to the terminal illness and related conditions. Therefore, the addendum could assist in more accurate claims submission, mitigate potential duplicative payments, and provide non-hospice providers with documentation to support a "without fault" determination. To provide transparency in how we believe this addendum reduces non-hospice provider burden, we have included a burden reduction estimate in section IV of this proposed rule. While this burden estimate assumes that an itemized list would be requested by every hospice beneficiary (or representative) receiving non-hospice services, or by the non-hospice providers rendering these unrelated services, we believe the actual burden would be less as hospices are already required to be comprehensive in their approach to covered services. As such, there would be hospices that would not have to complete the addendum as the hospice would be providing all items, services, and drugs.

We note that this addendum is not to be used by hospices as a vehicle in which to exercise unlimited ability to determine services as unrelated to the terminal illness and related conditions. It has always been CMS' expectation that hospice would be providing virtually all of the care needed by terminally ill individuals (48 FR 56010). Similarly, in a 1993 HCFA (now CMS)

ruling, "Weight To Be Given To a Treating Physician's Opinion In Determining Medicare Coverage Of Inpatient Care In a Hospital Or Skilled Nursing Facility," we stated that even though a physician's opinion is very important in making treatment determinations, no presumptive weight should be assigned to the treating physician's medical opinion alone, as coverage decisions are not made solely on this opinion.⁴⁸ That is, while the physician's determination carries great weight, other factors such as the condition of the patient upon admission, the nature of the principal diagnosis and the existence of comorbid conditions play an important role in coverage determinations. Hospices are to continue to make determinations about unrelated conditions, items, services, and drugs for each patient taking into account the needs, preferences and goals of the terminally ill individual and his or her family. In doing so, hospices are to conduct a thoughtful review of all of the beneficiary's conditions, related and unrelated to the terminal illness and related conditions, and current clinically relevant information supporting all diagnoses as required by regulation at § 418.25. This process requires clinical judgment in which hospices need to consider clinical practice guidelines and relevant research when making determinations of whether items, services, and drugs are related or unrelated to the terminal illness and related conditions.

We believe that the proposed election statement addendum, as a condition for payment, will achieve the goal of increasing comprehensive patient education, awareness, empowerment, and coverage transparency by:

- Providing information to the beneficiary (or representative), upon request, regarding those conditions, items, services, and drugs not covered by the hospice in an uncomplicated written format;
- Promoting informed consent;
- Encouraging discussion between the hospice and the terminally ill individual and their family regarding hospice covered and non-covered conditions, items, services, and drugs;
- Safeguarding patient rights and protecting the integrity of the hospice benefit by informing beneficiaries of an already established process through

⁴⁶ https://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=201809-0938-005.

⁴⁷ The False Claims Act, Title 3, section 3729. <https://www.govinfo.gov/content/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31.pdf>.

⁴⁸ HCFA Ruling No. 93-1, "Weight to Be Given to a Treating Physician's Opinion in Determining Medicare Coverage of Inpatient Care in a Hospital or Skilled Nursing Facility," May, 1993. <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/HCFAR931v508.pdf>.

which they are able to receive BFCC–QIO Immediate Advocacy to dispute the hospice’s determination regarding non-covered items and services for unrelated conditions when the beneficiary thinks they might be related;

- Providing a communication mechanism between hospice and non-hospice providers to help ensure benefit coordination for terminally ill patients.

This proposal outlines the modifications to the election statement content requirements and the required elements of the election statement addendum that we would require; we expect that hospices should already be complying with the existing, underlying coverage requirements. We are soliciting public comment on all aspects of the proposed modifications to the election statement content requirements, and the proposed election statement addendum, “Patient Notification of Hospice Non-Covered Items, Services, and Drugs,” as described in this section as well as the corresponding proposed revision to the regulations at § 418.24(b) in section VI of this proposed rule.

D. Request for Information Regarding the Role of Hospice and Coordination of Care at End-of-Life

The Medicare hospice benefit is currently only available as part of traditional, fee-for-service (FFS) Medicare as hospice care is excluded from the scope of what Medicare Advantage (MA) plans must offer under section 1852(a)(1)(B)(i) of the Act. MA enrollees that are eligible for and elect the hospice benefit remain in their MA plan, but receive hospice care through traditional FFS Medicare. In turn, CMS pays hospice organizations directly for hospice services based on the FFS payment system. Generally, following the month the enrollee elects hospice, CMS pays the MA plan the rebate amount, but not the risk-adjusted capitated amount for Part A and Part B services. The MA plan remains responsible for the provision of supplemental benefits, and in the case of an MA–PD, Part D drugs that the hospice has determined are unrelated to the enrollee’s terminal illness and related conditions. However, if the beneficiary requires items, services, or non-Part D drugs that the hospice has determined to be unrelated to the beneficiary’s terminal illness and related conditions, then the costs for any treatment are borne by Medicare FFS rather than the MA plan in accordance with the MA program’s special rules for hospice care at §§ 422.320(c)(3) and 417.585. Incorporating hospice into other kinds of care delivery models may be a way

of alleviating the payment fragmentation described above.

As outlined above, the Medicare hospice benefit is currently only available as part of traditional FFS Medicare. As part of delivery system transformation, we seek information on the interaction of the hospice benefit and various alternative care delivery models, including MA, Accountable Care Organizations (ACOs), and other future models designed to change the incentives in providing care under traditional FFS Medicare. Finally, we seek information on the impact of alternative delivery and payment models implemented outside of the Medicare program on the provision of hospice care and any lessons learned that we should consider for the future design of the Medicare hospice benefit. The questions and complexities around incorporating hospice into MA are indicative of the operational considerations that would need to be addressed around any long-term programmatic change, especially with regards to other contexts, such as ACOs or other models or changes within the Medicare hospice benefit to adapt to a changing payor mix and environment. For example, with respect to MA, unless an alternative approach to building hospice into the current bid for Part A and B services were followed, county benchmarks and the risk adjustment model would need to be revised to incorporate the cost of these beneficiaries. Additionally, although alternative network approaches might be considered, incorporating hospice into MA could result in MA plans only contracting with a subset of local hospices, thereby potentially limiting patient access and choice, and network adequacy standards would need to be developed by CMS. Additionally, given that CMS cannot and should not interfere in the contracting process between MA plans and their contracted providers, if hospice providers agree to payment rates that are lower than what Medicare currently pays that may result in changes in the quantity and types of services provided. One way managed care or value-based arrangements could address these issues may be to construct payments for hospice care such that they align closely with how hospices are paid under traditional FFS Medicare.

We note that we are testing ways to incorporate hospice into other kinds of care delivery models to alleviate payment fragmentation. One approach is to test incorporating hospice into MA under the CMS Innovation Center’s authority (section 1115A of the Social Security Act). Under this voluntary model, beginning in 2021, MA enrollees

in participating plans will have hospice care provided through their chosen MA plan. Through this RFI, we are seeking public comments on other broader approaches, beyond the model noted above, regarding the appropriate role of hospice as part of the care options available. Specifically, we are seeking public comments on how hospice under Medicare FFS relates to other treatment options, how it impacts the provision of a spectrum of care for those that need supportive and palliative care before becoming hospice eligible and after, and whether rates of live discharge are a reflection of the current structure of Medicare FFS. We are also seeking comment on any care coordination differences for hospice patients that received Medicare through traditional FFS prior to hospice election, were enrolled in an MA plan prior to hospice election, or received care from providers that participate in an Accountable Care Organization (ACO) prior to hospice election. Finally, we are soliciting public comments on the pros and cons of including hospice services as the part of the benefits provided in value-based or capitated payment arrangements given that some hospices likely have experience with ACOs and experience with Medicaid managed care when providing hospice care through the Medicaid program, as well as experience in providing hospice care to patients enrolled in “commercial coverage” (non-Medicare/Medicaid managed care plans). We believe the information gathered under this RFI will help to inform: (1) Future CMS payment models; (2) the role hospice with respect to ACOs; and (3) our general understanding of the traditional FFS hospice environment in relation to the increasing penetration of managed care through the MA program.

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

1. Background and Statutory Authority

The Hospice Quality Reporting Program includes meeting the reporting requirements for both the Hospice Item Set (HIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. Section 3004(c) of the Affordable Care Act amended section 1814(i)(5) of the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. Depending on the amount

of the annual update for a particular year, a reduction of 2 percentage points could result in the annual market basket update being less than 0 percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the particular year involved. Any such reduction would not be cumulative nor be taken into account in computing the payment amount for subsequent FYs. Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form, manner, and at a time specified by the Secretary.

2. Update to Quality Measure Development for Future Years

As stated in the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (83 FR 38622), we launched the Meaningful Measures initiative (which identifies high priority areas for quality measurement and improvement) to improve outcomes for patients, their families, and providers while also reducing burden on clinicians and providers. Meaningful Measures initiative is not intended to replace any existing programs, but will help programs identify and select individual measures. Meaningful Measure Initiative areas are intended to increase measure alignment across our programs and other public and private initiatives. Additionally, it will point to high priority areas where there may be gaps in available quality measures while helping guide our efforts to develop and implement quality measures to fill those gaps. More information about the Meaningful Measures initiative can be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html>.

The Meaningful Measures initiative fits well with the HQRP since it has changed little since we began with FY 2014 Hospice Wage Index and Payment Rate Update final rule, (76 FR 26806). The Meaningful Measures initiative enables us to review HQRP to close the gaps in quality measures to reflect the hospice industry as it has progressed to meet hospice care, including symptom management for its patients regardless of where hospice care is provided.

In the FY 2014 Hospice Wage Index and Payment Rate Update final rule (78 FR 48257), and in compliance with

section 1814(i)(5)(C) of the Act, we finalized the specific collection of data items that support the following 7 National Quality Forum (NQF)-endorsed measures for hospice:

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

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

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

Data for the “Hospice Visits when Death is Imminent” measure pair is being collected using new items added to the HIS V2.00.0, effective April 1, 2017.

Our goal is to identify measures that provide a window into hospice care throughout the dying process, fit well with the hospice business model, and meet the objectives of the Meaningful Measures initiative. Quality measures should provide timely, understandable, comprehensive, clinically valid, and meaningful feedback to hospice leadership, all of its staff, and their different teams regardless of the hospice setting where care is provided. We seek public input on measure concepts and/or actual quality measures along with public comment on the discussions presented below.

a. Claims-Based and Outcome Quality Measure Development for Future Years

As part of Meaningful Measures initiative, we seek to develop claims-based and outcome measures as part of the future for the HQRP. While we acknowledge that there are limitations of using claims data as a source for measure development, there are several

advantages to using claims data as part of a robust hospice quality reporting program. Claims-based measures place minimal burden on providers as they do not require additional data collection and data submission. Furthermore, in contrast to self-reported data that are dependent on hospice, patient, or caregiver participation, claims data has the benefit of following a relatively consistent format and of using a standard set of pre-established codes that describe specific diagnoses, procedures, and drugs. Additionally, nearly every encounter that a patient has with the healthcare system leads to the generation of a claim, creating an abundant and standardized source of patient information. This makes claims data widely available, relatively inexpensive, and amenable to analysis because they are readily available in an electronic format.

Medicare is the largest payer of hospice services and Medicare-certified providers predominate in hospice so it makes good sense to use claims data to reflect hospice care. Further, other settings, such as the Inpatient Quality Reporting Program (QRP) and the post-acute care (PAC) QRPs, have adopted claims-based measures, and the NQF has endorsed claims-based measures and believes they can capture quality even when not directly assessing clinical care. Although claims data have some limitations, such as incomplete reflection of care processes and patient outcomes, they will continue to be a valuable and important source of data for quality reporting for a selected set of metrics and as part of a hospice quality reporting program that includes other measures, such as HIS and CAHPS® Hospice Survey.

While not mutually exclusive of claims-based measures, we also seek to develop outcome measures as part of the Meaningful Measures initiative. Outcome measures could help with improving pain and symptom management, which is core to hospice care. They could also help identify the value of different staff providing care at different times in hospice. For these reasons, we plan to explore the development of other claims-based and outcome measures for the HQRP to work toward the high priority areas of reducing regulatory burden and identifying gaps in care. In identifying high priority areas for future measure enhancement and development, CMS takes into consideration input from all stakeholders including; Measures Application Partnership (MAP); the Office of the Inspector General (OIG); the Medicare Payment Advisory Commission (MedPAC); Technical

Expert Panels (TEP); issues raised through the Beneficiary and Family-Centered Care Quality Improvement Organization; and national priorities, such as those established by the National Priorities Partnership, the HHS Strategic Plan, the National Strategy for Quality Improvement in Healthcare, the CMS Quality Strategy, the Meaningful Measures initiative and the general public, such as through rulemaking. In addition, CMS considers feedback and input from published research and reports. We are not proposing any claims-based or outcome measures at this time. However, we are soliciting public comments and suggestions related to ideas for future claims-based and outcome measure concepts and quality measures in the HQRP that could also be tied to the goals of the Meaningful Measures initiative.

b. Update on Claims-Based Measure Development

The FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, (82 FR 36638), noted that, based on input from stakeholders, CMS has identified two “high priority” areas that will be addressed by claims-based measure development: Potentially avoidable hospice care transitions and access to levels of hospice care. The potentially avoidable hospice care transitions concept was developed as a measure under consideration called Transitions from Hospice Care, Followed by Death or Acute Care. The goal of this measure is to identify hospices that have notably higher rates of live discharges followed shortly by death or acute care utilization, when compared to their peers. Details about this measure can be found in the FY 2017 Hospice Wage Index and Payment Rate Update and the NQF website, <http://www.qualityforum.org/map/>, where it went on the measures under consideration (MUC) list in July 2018 and was reviewed by the MAP in December 2018. At this time, we are revisiting the potentially avoidable hospice care transitions. While MAP did not support the measure as specified, MAP recognized the impact that care transitions at the end of life can have on patients and suggested a number of ways MAP’s concerns with the measure could be mitigated. Areas that the MAP recommended included reconsidering the exclusion criteria for the measure. Specifically, the exclusion for Medicare Advantage patients should be reviewed as this may be excluding too many patients. Additionally, the MAP suggested adding an exclusion to allow for patient choice, as there are a number

of reasons a patient may choose to transition from hospice. For example, a patient may choose to pursue additional curative treatment, have cultural beliefs that influence the definition of a good death, have limited access to primary care, or may need to revoke the hospice benefit to avoid a financial penalty for seeking more acute care. MAP also noted that the measure may provide more useful information if it separates out the concepts addressed in the measure, as the measure may be trying to address different concepts by including both death within 30 days and admission to an acute care use within 7 days. The MAP also requested to consider shortening the timeframe for the measure, MAP 2019 Considerations for Implementing Measures in Federal Programs: Post-Acute Care and Long-Term Care, Final Report February 15, 2019, <https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89400>.

The access to levels of hospice care measure concept is also detailed in the FY 2018 Hospice Wage Index and Payment Rate Update. After further analyses, it was determined that this measure concept as currently specified could result in hospices providing higher levels of care when it is not required by the plan of care or expected by CMS. We remain committed to developing claims-based measures that meet high priority areas and are rethinking both measures based on feedback from the MAP and our analyses. We are seeking public comment on ways to further develop these two measure concepts and different measure concepts that fall under these high priority areas.

c. Update on the Hospice Assessment Tool

We discussed the plan to develop a hospice assessment tool in the FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, (82 FR 36638). A technical expert panel on development of such an assessment tool was held in October 2017 followed by a pilot study that began with training 9 hospice sites in December 2017. We are sincerely thankful for and appreciative of the 9 Medicare hospices that participated in the pilot study. We learned much from them during the pilot study and afterwards in lessons learned interviews. Information from that pilot study, referred to as Pilot A, can be found on the HQRP website at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HEART.html>. We also discussed Pilot A

findings, lessons learned, and goals of a hospice assessment tool at the September 2018 special open door forum (SODF). The transcript for that SODF can be found at, <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html>. Key concepts in developing a hospice assessment tool include understanding the care needs of people through the dying process and ensuring the safety and comfort of individuals enrolled in hospice institutions nationwide. Currently we collect data at admission and discharge via HIS that are used to calculate measures in the HQRP. We would like to replace HIS and capture data with a hospice assessment instrument in order to bridge the gap to achieve a fuller understanding of patient care needs. While it must be recognized that hospice care differs from other PAC settings, there is a need to create a comprehensive assessment instrument for hospice care to align with other PAC settings, where feasible and practical. As such, objectives of a comprehensive assessment instrument must include the ability to establish goals of care that embrace the individual’s values and preferences, and are consistent with a person-centered approach that values the person and caregiver in the care continuum with an emphasis on physical, psychosocial, spiritual, and emotional support. We continue our commitment to engaging stakeholders at regular SODF meetings and/or other means like the HQRP website, open door forums (ODF), webinars, and other sub-regulatory means.

One of the requests raised at the September 2018 SODF was to change the name of the hospice assessment tool from Hospice Evaluation Assessment Reporting Tool (HEART) to a name that is not as easily confused with other HQRP related tools like the Hospice Abstraction Reporting Tool (HART). We agree with this feedback since people refer to both by their same sounding acronyms and seek public comment on the name for the hospice assessment tool.

We will keep providers informed about future measure and assessment tool development efforts and solicit key stakeholder input through regular sub-regulatory channels. Additionally, future measure concepts under development, including details regarding measure definitions, data sources, data collection approaches, and timeline for implementation will be communicated in future rulemaking.

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

a. Background

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

b. Update on the CMS System for Reporting Quality Measures and Standardized Patient Assessment Data and Associated Procedural Proposals

Hospices are currently required to submit HIS data to CMS using the Quality Improvement and Evaluation System (QIES) Assessment and the Submission Processing (ASAP) system. We will be migrating to a new internet Quality Improvement and Evaluation System (iQIES) as soon as FY 2020 that will enable us to make real-time upgrades, and we are designating that system as the data submission system for the Hospice QRP. Effective October 1, 2019, we are proposing to notify the public of any changes to the CMS-designated system in the future using sub-regulatory mechanisms such as web page postings, listserv messaging, and webinars. We are inviting public comment on this proposal.

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

a. Background and Description of the CAHPS® Hospice Survey

The CAHPS® Hospice Survey is a component of the CMS HQRP which is used to collect data on the experiences of hospice patients and the primary caregivers listed in their hospice records. Readers who want more information about the development of the survey, originally called the Hospice Experience of Care Survey, may refer to 79 FR 50452 and 78 FR 48261. National implementation of the CAHPS® Hospice Survey commenced January 1, 2015 as stated in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452).

b. Overview of the CAHPS® Hospice Survey Measures

The CAHPS® Hospice Survey measures received NQF endorsement on October 26th, 2016 (NQF #2651). We adopted these 8 survey based measures for the CY 2018 data collection period and for subsequent years. These 8 measures are reported on Hospice Compare.

c. Data Sources

We previously finalized the participation requirements for the FY 2020, FY 2021, and FY 2022 APUs (see 82 FR 36673). We propose to extend the same participation requirements for the HQRP for FY 2023 and all future years. As part of the Patients Over Paperwork initiative, we solicit comments about the CAHPS Hospice Survey questionnaire. We seek comments regarding suggested changes, additions or deletions to the instrument that would improve its value to hospices for quality improvement and consumers for selecting a hospice.

d. Public Reporting of CAHPS® Hospice Survey Results

We began public reporting of the results of the CAHPS® Hospice Survey on Hospice Compare as of February 2018. We report the most recent 8 quarters of data on the basis of a rolling average, with the most recent quarter of data being added and the oldest quarter of data removed from the averages for each data refresh. We refresh the data 4 times a year in the months of February, May, August, and November.

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

We previously finalized a volume-based exemption for CAHPS® Hospice Survey Data Collection and Reporting requirements in the FY 2017 Hospice Wage Index and Payment Rate Update final rule (82 FR 36671). We propose to continue our policy for a volume-based exemption for CAHPS® Hospice Survey Data Collection for FY 2021 and every year thereafter. For example, for the FY 2021 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2018 through December 31, 2018 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements (corresponds to the CY 2019 data collection period). To qualify,

hospices must submit an exemption request form for the FY 2021 APU. The exemption request form is available on the official CAHPS® Hospice Survey website: <http://www.hospiceCAHPSsurvey.org>. Hospices that intend to claim the size exemption are required to submit to CMS their completed exemption request form covering their total unique patient count for the reference year (for the CY 2019 data collection period the reference year is January 1, 2018 through December 31, 2018). The due date for submitting the exemption request form for the FY 2021 APU is December 31, 2019. Exemptions for size are active for 1 year only. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization needs to request the exemption annually for every applicable FY APU period by the final day of the calendar year. Subsequent periods will follow the same pattern of using the year before the data collection year as the reference year for determining eligibility.

Starting with FY 2022 we propose to provide an automatic exemption to any hospice that (1) is an active agency and (2) according to CMS data sources has served less than a total of 50 unique decedents/caregivers in the reference year. The automatic exemption is good for 1 year and will be reassessed in subsequent years. Hospices with fewer than 50 unique decedents/caregivers in the reference year would not be required to submit an exemption request form.

Hospices that have a total patient count of more than 50 unique decedents/caregivers in the reference year, but who have a total of fewer than 50 survey-eligible decedents/caregivers will not be granted an automatic exemption. For example, hospices may have more than 50 unique decedents/caregivers, but have some decedents/caregivers who are not eligible to be sampled for the CAHPS Hospice Survey, which would therefore lead to fewer than 50 survey-eligible decedents/caregivers. Such hospices may qualify for a size exemption. To do so, they must apply for a size exemption by submitting the size exemption request form as outlined above. This exemption is valid for 1 year only. If the hospice remains eligible for the size exemption, it must request the exemption annually for every applicable FY APU period. We solicit feedback on these proposals.

TABLE 16—SIZE EXEMPTION KEY DATES 2021 THROUGH FY 2025

| Fiscal year | Data collection year | Reference year | Size exemption form submission deadline |
|---------------|----------------------|----------------|---|
| FY 2021 | 2019 | 2018 | December 31, 2019. |
| FY 2022 | 2020 | 2019 | December 31, 2020. |
| FY 2023 | 2021 | 2020 | December 31, 2021. |
| FY 2024 | 2022 | 2021 | December 31, 2022. |
| FY 2025 | 2023 | 2022 | December 31, 2023. |

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

We previously finalized a one-time newness exemption for hospices that meet the criteria as stated in the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52181). In the FY 2019 Hospice Wage Index and Payment Rate Update final rule (83 FR

38642), we continued the newness exemption for FY 2023, FY 2024, FY 2025, and all future years. We encourage hospices to keep the letter they receive providing them with their CCN. The letter can be used to show when you received your number.

g. Survey Participation Requirements

We previously finalized survey participation requirements for FY 2022

through FY 2025 as stated in the FY 2018 and FY 2019 Hospice Wage Index and Payment Rate Update final rules (82 FR 36670 and 83 FR 38642 through 38643). We propose to continue those requirements in all subsequent years. Below we reprint the Hospice Survey data submission dates finalized in the FY 2019 Hospice Wage Index and Payment Rate Update final rule (83 FR 38643).

| Sample months (month of death) ¹ | CAHPS® quarterly data submission deadlines ² |
|---|---|
| FY 2023 APU | |
| CY January–March 2021 (Quarter 1) | August 11, 2021. |
| CY April–June 2021 (Quarter 2) | November 10, 2021. |
| CY July–September 2021 (Quarter 3) | February 9, 2022. |
| CY October–December 2021 (Quarter 4) | May 11, 2022. |
| FY 2024 APU | |
| CY January–March 2022 (Quarter 1) | August 10, 2022. |
| CY April–June 2022 (Quarter 2) | November 9, 2022. |
| CY July–September 2022 (Quarter 3) | February 8, 2023. |
| CY October–December 2022 (Quarter 4) | May 10, 2023. |
| FY 2025 APU | |
| CY January–March 2023 (Quarter 1) | August 9, 2023. |
| CY April–June 2023 (Quarter 2) | November 8, 2023. |
| CY July–September 2023 (Quarter 3) | February 14, 2024. |
| CY October–December 2023 (Quarter 4) | May 80, 2024. |

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

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

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

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

a. Background

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any quality data submitted by hospices available to the public. These procedures shall ensure that a hospice has the opportunity to

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

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

added to the website, and in November 2018, the Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (NQF #3235) was added to the website.

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

1. Background and Description of “Hospice Visits When Death Is Imminent” Measure Pair

In the FY 2017 Hospice Wage Index and Payment Rate Update (81 FR 52163 to 52169, August 6, 2016), we finalized the “Hospice Visits when Death is Imminent” measure pair for

implementation April 1, 2017. This measure pair assesses whether the needs of hospice patients and their caregivers were addressed by the hospice staff during the last days of life. The “Hospice Visits when Death is Imminent” measure pair is made up of two measures, Measure 1 and Measure 2. Measure 1 of the pair assesses the percentage of patients receiving at least 1 visit from a registered nurse, physician, nurse practitioner, or physician assistant in the last 3 days of life. Measure 2 assesses the percentage of patients receiving at least 2 visits from social workers, chaplains or spiritual counselors, licensed practical nurses, or aides in the last 7 days of life.

2. Update to Public Reporting of the “Hospice Visits When Death Is Imminent” Measure Pair

As stated in the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (83 FR 38643 to 38645, August 6, 2018), quality measures are added to Hospice Compare once they meet the readiness standards for public reporting, which is determined through rigorous testing for reliability, validity, and reportability. Since the proposal of the “Hospice Visits when Death is Imminent” measure pair, CMS has conducted further measure testing activities according to National Quality Forum (NQF) guidelines and the Blueprint for the CMS Measures Management System Version 14.0 available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/BlueprintVer14.pdf>. This testing is conducted to ensure that measures 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.

As we assessed the scientific acceptability of “Hospice Visits when Death is Imminent” measure pair, we determined that Measure 1 meets established standards for reliability, validity, and reportability. Therefore, the measure will be publicly reported in FY 2019 as stated in the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (83 FR 38645 to 38648). Our testing of Measure 2 of the “Hospice Visits when Death is Imminent” measure pair (referred to as Measure 2) revealed that the measure does not meet readiness standards for public reporting at this time and additional testing is needed before we are able to make a decision on the

public reporting of Measure 2. Therefore, we have decided not to publish Measure 2 of the “Hospice Visits when Death is Imminent” measure pair at this time. See our discussion on our website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Background-and-Announcements.html> for more information.

Although Measure 2 will not be publicly reported at this time, we believe that Measure 2 focuses on an important aspect of quality care for imminently dying patients. Therefore, we will include quality performance data on the measure in each hospice’s confidential Quality Measure Reports and the Review and Correct Report available on the Certification and Survey Provider Enhanced Reporting (CASPER) system. Hospices will also still receive credit for reporting on Measure 2 as part of the HQRP requirements. Furthermore, Measure 2 aligns with our Meaningful Measures initiative and its quality priorities, particularly “Strengthen Person and Family Engagement as Partners in Their Care—End of Life Care according to Preferences.” While Measure 1 of the “Hospice Visits when Death is Imminent” measure pair (referred to as Measure 1) addresses case management and clinical care, Measure 2, which includes visits from social workers, chaplains or spiritual counselors, licensed practical nurses, and aides, recognizes providers’ flexibility to provide individualized care from a variety of disciplines that is in line with the patient, family, and caregiver’s preferences and goals for care and contributes to the overall well-being of the individual and others important to them at the end of life. As such, we believe that Measure 2 addresses a high-priority measure area where there is significant opportunity for improvement, as well as is meaningful to patients, clinicians, and providers alike.

We will conduct additional testing on Measure 2 to determine if and how the measure specifications may be modified or re-specified, and/or if the method for displaying the measure may be adjusted, so that this measure meets the highest standards of scientific acceptability and reportability. Additional testing will also ensure that Measure 2 is thoroughly evaluated to determine that it meets the criteria for display on Hospice Compare.

The results of the additional testing will inform the next steps regarding the public reporting of Measure 2 of “Hospice Visits when Death is

Imminent” measure pair. As stated in the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (83 FR 38643), we will inform providers of updates to testing and public reporting of quality measures, including Measure 2 of the “Hospice Visits when Death is Imminent” measure pair, through sub-regulatory channels and regular HQRP communication strategies, such as Open Door Forums, Medicare Learning Network, CMS.gov website announcements, listserv messaging, and other opportunities.

While we have decided not to publicly report Measure 2 of the “Hospice Visits when Death is Imminent” measure pair on the Provider Preview Reports and Hospice Compare at this time, the measure will remain on provider’s CASPER Quality Measure (QM) Reports. CASPER QM Reports are intended for providers’ internal use and are meant to aid hospices in quality improvement efforts. Although the measure will not be publicly reported at this time, we believe that it is important for providers to internally review and be informed by these data, to ensure that they are providing their patients and caregivers the individualized support they need in the patients’ last days of life. Our decision not to publicly report Measure 2 of the “Hospice Visits when Death is Imminent” measure pair at this time is distinct from our interest in continuing collecting these data. Specifically, these data are needed to determine whether a measure meets all the criteria for public reporting. Continued data collection will enable us to test and modify or re-specify a measure so that these criteria are satisfied. We seek to balance these data collection effort with the section 1814(i)(5)(E) of the Act, which states, “The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the internet website of the Centers for Medicare & Medicaid Services.” We believe that information required for the robust analyses to further develop this measure, modify or re-specify it to allow for public reporting justifies continuing data collection.

The data collection and submission requirements for the “Hospice Visits When Death is Imminent” measure pair will not change in order to collect the data for measure 1, which will be publicly reported beginning with FY 2019. Measure 2, which will not be publicly reported at this time, needs to be further evaluated for modification or re-specification. Measure 2 of “Hospice Visits when Death is Imminent” measure pair is calculated using items

O5010, O5020 and O5030 from the HIS V2.00.0. These items collect data on hospice visits in the final 3 days of life, level of care in the final 7 days of life, and hospice visits in the three to six days prior to death. Because the measure is not being removed from the HQRP, providers should continue to complete these items accurately and completely and submit HIS records to us in a timely manner. We require data from Section O to calculate Hospice Visits when Death is Imminent Measure 1, which will be publicly reported on Hospice Compare beginning in FY 2019. Therefore, we propose continued collection of this data to complete additional testing and to make a determination about the public reporting of Measure 2 of the “Hospice Visits when Death is Imminent” measure pair. We expect to complete

our analysis by the end of FY 2020, and determine next steps for public reporting based on meeting established standards for reliability, validity, and reportability.

We are cognizant and respectful of the time and effort that hospices take to complete the HIS V2.00.0 items used to calculate and test Measure 2. We will continually evaluate the volume and robustness of the resulting data to determine when data collection is no longer required.

c. Display of Publicly Available Government Data on the Hospice Compare Website

1. Update to Posting of Public Use File (PUF) Data to the Hospice Compare Website

In the FY 2019 Hospice Wage Index and Payment Rate Update and Hospice

Quality Reporting Requirements (83 FR 38649), we finalized plans to publicly post information from the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (PUF) and/or other publicly available CMS data to the Hospice Compare website. This PUF data, along with clear text explaining the purpose and uses of this information and suggesting consumers discuss this information with their healthcare provider, will be displayed under a new “General information” section on Hospice Compare in summer 2019. This new section will precede the existing “Family Experience of Care” section on the Hospice Compare website. Tables 17 through 19 show how these data will be displayed on Hospice Compare.

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Table 17: Mock-up of Level of Care Provided Information on Hospice Compare

| Level of care provided in calendar years 2014, 2015, and 2016 | Hospice A Average Daily Census: 345 Date Certified: 04/01/1995 | Hospice B Average Daily Census: 67 Date Certified: 04/01/2002 | Hospice C Average Daily Census: Not available Date Certified: 04/01/2017 | National Average Average Daily Census: 74 |
|--|---|--|---|--|
| Provided Routine Home Care <u>only</u> | ✓ | | Not Available | 3.1% |
| Provided Routine Home Care <u>and</u> other levels of care | | ✓ | Not Available | 96.9% |

Note: Information is “Not Available” for Hospice C because the hospice was Medicare-certified in 2017. PUF data is only available through 2016.

Table 18: Mock-up of Primary Diagnosis Information on Hospice Compare

| Medical Conditions | Hospice A Average Daily Census: 345 Date Certified: 04/01/1995 | Hospice B Average Daily Census: 67 Date Certified: 04/01/2002 | Hospice C Average Daily Census: Not available Date Certified: 04/01/2017 | National Average Average Daily Census: 74 |
|---------------------------|---|--|---|--|
| Cancer | 18.3% | 45.6% | Not Available | 27.3% |
| Dementia | 45.5% | 20.7% | Not Available | 21.1% |
| Stroke | Less than 11 patients | 18.9% | Not Available | 9.4% |
| Heart Disease | 17.8% | | Not Available | 20.8% |
| Respiratory Disease | | 17.0% | Not Available | 11.9% |
| Other | Less than 11 patients | Less than 11 patients | Not Available | 16.1% |

Note: Information is “Not Available” for Hospice C because the hospice was Medicare-certified in 2017. PUF data is only available through 2016. “Less than 11 patients” indicates the hospice served less than 11 patients with the indicated condition in 2016. Data for hospice providers who served between 0 and 11 patients with a particular condition is not reported in the PUF to protect personal health information and ensure publicly reported data is a reliable indication of services provided by the hospice.

Table 19: Mock-up of Location of Care Information on Hospice Compare

| Location | Hospice A Average Daily Census: 345 Date Certified: 04/01/1995 | Hospice B Average Daily Census: 67 Date Certified: 04/01/2002 | Hospice C Average Daily Census: Not available Date Certified: 04/01/2017 | National Average Average Daily Census: 74 |
|-----------------------------|---|--|---|--|
| Home | ✓ | ✓ | Not Available | 99.8% |
| Assisted Living Facility | ✓ | ✓ | Not Available | 76.1% |
| Nursing Facility | ✓ | Less than 11 patients | Not Available | 60.8% |
| Skilled Nursing Facility | Less than 11 patients | ✓ | Not Available | 52.5% |
| Inpatient Hospital Facility | ✓ | | Not Available | 31.5% |
| Inpatient Hospice | | Less than 11 patients | Not Available | 17.0% |

| | | | | |
|---------------------|-----------------------|---|---------------|-------|
| Facility | | | | |
| All other locations | Less than 11 patients | ✓ | Not Available | 17.6% |

Note: Information is “Not Available” for Hospice C because the hospice was Medicare-certified in 2017. PUF data is only available through 2016. “Less than 11 patients” indicates the hospice served less than 11 patients in the indicated location in 2016. Data for hospice providers who served between 0 and 11 patients in a particular location is not reported in the PUF to protect personal health information and ensure publicly reported data is a reliable indication of services provided by the hospice.

2. Proposal to Post Information From Government Data Sources to the Hospice Compare Website

As part of our ongoing efforts to make the Hospice Compare website more meaningful and informative to our beneficiaries, their caregivers, and families, we propose to post information from other publicly available government data, in addition to the data from the PUF or other CMS sources, to the Hospice Compare website at some time in the future. We are proposing to be able to use informative data from other government sources on Hospice Compare in the future and as soon as FY 2020. Examples, provided for illustration, from where CMS could pull publicly available government data include the United States Census Bureau, Centers for Disease Control and Prevention, and National Institutes of Health.

We may use information available in these public government files to augment the “General Information” section described above. This “General Information” section including PUF data and, if this proposal is finalized, information from other public government data will provide additional information along with the HIS and CAHPS® quality measures that are already displayed.

Any future reporting of public government data on the Hospice Compare website will be displayed in a consumer-friendly format. This means we may display the data as shown in these publicly available government files or present the data after additional calculations. For example, the data could be averaged over multiple years, displayed as a percentage rather than the raw number, or other calculations could be based on a given year or over multiple years, so the data has meaning to end-users. Furthermore, by performing these calculations, we can make the data apply to hospices broadly regardless of size, location, or other factors.

Also, we would like to note that data used from these publicly available sources are not quality measures. Rather, they present supplementary information that many consumers seek

during the provider selection process and, therefore, will help them to make an informed decision. This is similar to other useful information we already display on Hospice Compare under the Spotlight, Tools and Tips, and Additional Information sections on the Hospice Compare homepage. Data from publicly available data sources can serve as one more piece of information, along with quality of care metrics from the HIS and CAHPS® Hospice Survey and other useful information, to help consumers effectively and efficiently compare hospice providers and make an informed decision about their care in a stressful time. We also believe such information may be useful to providers. For example, adding information from the United States Census Bureau may help consumers better understand the service area in which they are looking for services (for example, if there is a large population of people from a similar race/ethnicity in the area). This information may also help providers better understand their service area to see if there are any business development opportunities (for example, if there is a large population of a similar race/ethnicity, the provider may consider investing resources in better serving patients from this background).

To ensure that end-users understand that these data provide information about hospice characteristics and are not a reflection of the quality of care a hospice provides, we will, with consultation from key stakeholders, carefully craft explanatory language to ensure that consumers understand the information and how the data are meant for informational purposes only.

As we determine which publicly available government data sources we will use and how we will be using and presenting information from these sources, we will inform the public and engage with stakeholders via sub-regulatory processes, including regular HQRP communication strategies such as Open Door Forums, Medicare Learning Network, Spotlight Announcements, and other opportunities.

We are soliciting public comment on our proposal to post information from publicly available government sources

to the Hospice Compare website in the future.

IV. Collection of Information Requirements

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

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

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

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

A. Election Statement Addendum: “Patient Notification of Hospice Non-Covered Items, Services, and Drugs”

To calculate this burden estimate, we use salary information from the Bureau of Labor Statistics (BLS) website at <https://www.bls.gov/> and include a fringe benefits package worth 100 percent of the base salary. The mean hourly wage rates are based on May, 2017 BLS data for each discipline. Table 20 contains our burden estimate assumptions for the proposed Election Statement Addendum: “Patient Notification of Hospice Non-Covered

Items, Services, and Drugs” discussed in section III.C. of this proposed rule.

TABLE 20—ELECTION STATEMENT ADDENDUM: “PATIENT NOTIFICATION OF HOSPICE NON-COVERED ITEMS, SERVICES, AND DRUGS” BURDEN ESTIMATE ASSUMPTIONS

| | |
|---|---------------------------------|
| Number of Medicare-billing hospices, from FY 2017 Medicare Enrollment Database, Provider of Service files. | 4,465. |
| Number of hospice elections in FY 2017 | (1,268,497 × 0.84) = 1,065,537. |
| Hourly rate of an office employee (Executive Secretaries and Executive Administrative Assistants, 43–6011). | \$57.12 (\$28.56 × 2.00). |
| Hourly rate of an administrator (General and Operations Managers, 11–1021) | \$118.70 (\$59.35 × 2.00). |
| Hourly rate of registered nurses (Registered Nurses, 29–1141) | \$70.72 (\$35.36 × 2.00). |
| Hourly rate of pharmacy technicians (Pharmacy Technicians, 29–2052) | \$31.80 (\$15.90 × 2.00). |

Source: FY 2017 hospice claims data. 16 percent of beneficiaries die within the first 48 hours. Hospices are exempt for completing addendum if beneficiary dies within first 48 hours.

Section 1814(a)(7) of the Act requires for the first 90-day period of a hospice election the individual’s attending physician (as defined in section 1861(dd)(3)(B) of the Act) (which for purposes of this subparagraph does not include a nurse practitioner), and the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B) of the Act) of the hospice program providing (or arranging for) the care, each certify in writing, at the beginning of the period, that the individual is terminally ill (as defined in section 1861(dd)(3)(A) of the Act). The regulations codified at §§ 418.22 and 418.25 provide the requirements regarding the certification of terminal illness and admission to hospice care. The hospice medical director must specify that the individual’s prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. Additionally, clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. The physician 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. The aforementioned regulations also require that the hospice medical director must consider both related and unrelated conditions and current clinically relevant information when making the decision to certify the individual as terminally ill. Likewise, the hospice CoPs at § 418.102(b) provide the requirements regarding the certification responsibility of the hospice medical director or hospice physician designee which includes a review of the clinical information, including both related and unrelated conditions, for each hospice patient.

In order to receive hospice services under the Medicare hospice benefit, eligible beneficiaries must elect to

receive hospice care by completing an election statement. By signing this election statement, the individual acknowledges that he/she waives all rights to Medicare payments for treatment related to the terminal illness and related conditions. The content requirements for the hospice election statement are listed at § 418.24(b) and each hospice election statement must include the following information:

- Identification of the particular hospice and of the attending physician that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice.
- The individual’s or representative’s acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual’s terminal illness.
- Acknowledgement that certain Medicare services, as set forth in § 418.24(d), are waived by the election.
- The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.
- The signature of the individual or representative.

Once a beneficiary is certified as terminally ill and elects the Medicare hospice benefit, the hospice conducts an initial assessment visit in advance of furnishing care. During this visit, the hospice must provide the patient or representative with verbal and written notice of the patient’s rights and responsibilities as required by the CoPs at § 418.52. Likewise, the regulations at § 476.78 state that providers must inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to Quality Improvement Organization (QIO) review.

The beneficiary needs identified in the initial and comprehensive assessments drive the development and revisions of an individualized written plan of care for each patient as required by the hospice CoPs at § 418.56. The hospice plan of care is established, reviewed and updated by the hospice IDG and must include all services necessary for the palliation and management of the terminal illness and related conditions. While needs unrelated to the terminal illness and related conditions are not the responsibility of the hospice, the hospice may choose to furnish services for those needs regardless of responsibility. However, if a hospice does not choose to furnish services for those needs unrelated to the terminal illness and related conditions, the hospice is to communicate and coordinate with those health care providers who are caring for the unrelated needs, as described in § 418.56(e). In accordance with the CoPs, the hospice must document the services and treatments that address how they will meet the patient and family-specific needs related to the terminal illness and related conditions in the plan of care, and those needs unrelated to the terminal illness and related conditions that are present when the patient elects hospice should also be documented. This documentation ensures that the hospice is aware of those unrelated needs and who is addressing them. This documentation provides the support for the hospices’ financial responsibility for the hospice services they will be providing. There is limited beneficiary financial liability for hospice services upon election of the Medicare hospice benefit. However, for any services received that are unrelated to the terminal illness and related conditions, the beneficiary would incur any associated copayments and coinsurance.

Hospices already are required to review, determine, and document information on unrelated conditions per the hospice regulations and CoPs. However, to ensure Medicare beneficiaries are provided disclosure of those conditions, items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions at the time of admission, we propose to add to the regulations at § 418.24(b) and (c), the requirement of an election statement addendum titled “Patient Notification of Hospice Non-Covered Items, Services, and Drugs” that would be issued to the patient (or representative) within 48 hours of the hospice election date to ensure that Medicare beneficiaries are fully informed whether or not all items, services, and drugs identified on the hospice plan of care will be furnished by the hospice. The addendum statement would not be required if the beneficiary died within 48 hours of the hospice election date. This addendum would accompany the hospice election statement and each hospice would use the required proposed elements to develop and design their own addendum to best meet their needs and the requirement. This requirement for payment would be added to the regulations at § 418.24(b) and (c).

The burden associated with the documentation requirement for the addendum includes the time for each hospice to develop the addendum that the hospice provides to the beneficiary (or their representative) within 48 hours of election of the Medicare hospice benefit. The addendum must include the name of the issuing hospice, beneficiary's name, and hospice medical record identifier. The addendum must also allow the hospice registered nurse to document a list of non-covered conditions, items, services, and drugs, as well as provide a clinical explanation as to why these conditions, items, services, and drugs have been determined to be unrelated to the terminal illness and related conditions. This documentation would include references to any relevant clinical practice, policy, or coverage guidelines. The addendum must include statements informing the patient as to the purpose of the addendum and information on BFCC-QIO Immediate Advocacy rights and contact information. The addendum

would be signed by the beneficiary as an acknowledgement that he or she has received this information, but signing it does not mean the beneficiary agrees with the determination. We believe that the burden for the hospice associated with the election statements addendum would be the cost of developing the form and the cost of filling out the form. There is no associated burden for hospices to communicate/coordinate with non-hospice providers regarding the content of the addendum statement because the hospice CoPs, as described above, have always required hospices to have a system of communication with non-hospice providers in place. However, we believe that the election statement addendum would reduce burden for non-hospice providers through a consistent and streamlined process by which non-hospice providers can make informed treatment decisions and accurately submit claims with the appropriate condition code or modifier.

1. Estimated Hospice Burden With Election Statement Addendum

a. Estimated One-Time Form Development

We estimate a one-time burden for the development of the election statement addendum. We estimate that it would take a hospice administrative assistant 15 minutes ($15/60 = 0.25$ hours) to develop the addendum with the required elements, and the hospice administrator 15 minutes ($15/60 = 0.25$ hours) to review the addendum. The clerical time plus administrator time equals a one-time burden of 30 minutes or ($30/60 = 0.50$ hours) per hospice. For all 4,465 hospices, the total time required would be ($0.50 \times 4,465$) = 2,232.5 hours. At \$57.12 per hour for an executive administrative assistant, the cost per hospice would be ($0.25 \times \$57.12$) = \$14.28. At \$118.70 per hour for the administrator's time, the cost per hospice would be ($0.25 \times \$118.70$) = \$29.68. Therefore, the one-time cost, per hospice, for the development of the form would be ($\$14.28 + \29.68) = \$43.96, and the total one-time cost for all hospices would be ($\$43.96 \times 4,465$) = \$196,281.

b. Estimated Time for Hospice To Complete Addendum

Per the hospice CoPs at § 418.56(a), the hospice must designate a registered

nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The hospice CoPs at § 418.54 require that a registered nurse conduct the initial assessment, therefore, the registered nurse would be responsible for completing the addendum for each hospice election as part of the routine admission paperwork. We estimate that there would be 1,268,497 hospice elections in a year based on FY 2017 claims data. Approximately 16 percent of hospice beneficiaries die within the first 48 hours after the hospice election date. Hospices would not be required to complete the election statement addendum for those hospice beneficiaries that die within 48 hours of hospice election. Therefore, the estimated total number of hospice elections in FY 2020 that would require the hospice election statement addendum would be ($1,268,497 \times 0.84$) = 1,065,537. There are 4,465 Medicare-certified hospices, so on average there would be ($1,065,537/4,465$) = 239 hospice elections per hospice. The estimated burden for the hospice registered nurse to extrapolate this information from the existing documentation in the patient's hospice medical record and complete this addendum would be 10 minutes ($10/60 = 0.1667$). At \$70.72 per hour for a registered nurse over 10 minutes ($0.1667 \times \$70.72 = \11.79), we estimate the total cost of RN time to complete the addendum per hospice in FY 2020 to be ($\$11.79 \times 239$) = \$2,818, and the total cost of RN time to complete the addendum for all hospices in FY 2020 would be ($\$2,818 \times 4,465$) = \$12,582,370. The estimated total per hospice and total annual hospice cost associated with the proposed addendum (including one-time form development and total RN costs) in FY 2020 are shown in table 21 below. These total costs would include the one-time development of the addendum, so subsequent years' costs would only include the cost for the RN to complete the addendum statement. Providing this information to the beneficiary would be part of the routine admissions process and, as such, incurs no additional burden to that process.

Table 21: FY 2020 Estimated Per Hospice and Total Hospice Costs for Election Statement Addendum

| | Average # Of Elections Per Hospice | Total # of Hospice Elections (based on FY 2017) |
|--|---|--|
| Number of Hospice Elections | 239 | 1,065,537 |
| | | |
| | Average Cost Per Hospice | Total Annual Costs for All Hospices |
| Total # of Hospices | | 4,465 |
| One-time Form Development | \$43.96 | \$196,281 |
| | | |
| RN Form Completion | \$2,818 | \$12,582,370 |
| Total Hospice Estimated FY 2020 Costs | | \$12,778,651 |

Source: FY 2017 CWF Claims Data, Medicare Enrollment Database, and Provider of Service (POS). Enrollment data.

2. Estimated Burden Reduction for Non-Hospice Providers

To ensure comprehensive and coordinated care, the CoPs at § 418.56(e) require hospices to have a communication system that allows for the exchange of information with other non-hospice health care providers who are furnishing care unrelated to the terminal illness and related conditions. Therefore, it is our expectation that hospices are already determining what is related and unrelated to the terminal illness and related conditions. The election statement addendum would add no additional burden for communicating with non-hospice providers, as this decision-making process has been a long-standing CoP requirement, as described above and in the preamble of this proposed rule. However, burden would be reduced for non-hospice providers, including institutional, non-institutional and pharmacy providers because less time would be spent trying to obtain needed information for treatment decisions and accurate claims submissions.

To estimate the cost burden reduction, we first calculated the estimated current burden, in the absence of the addendum, for

communicating and coordinating information regarding unrelated conditions between hospice and non-hospice providers. Next, we calculated the estimated burden, using the addendum for communicating and coordinating information regarding unrelated conditions between hospice and non-hospice providers. Finally, we analyzed the difference between the burden estimates to see if there is any overall reduction. To do this, we analyzed all Medicare Parts A and B non-hospice claims for beneficiaries under a hospice election in FY 2017. We also examined the Part D claims for drugs provided to hospice beneficiaries under a hospice election. Specifically, we analyzed the following:

- The total number of non-hospice, institutional claims with condition code 07 (to indicate the services were unrelated to the terminal illness and related conditions).
- The total number of non-hospice, non-institutional claims with “GW” modifier (to indicate the services were unrelated to the terminal illness and related conditions).
- The total number of Part D claims for beneficiaries under a hospice election.

- The average number of hospice beneficiaries per non-hospice provider with institutional claims with condition code 07.

- The average number of hospice beneficiaries per non-hospice provider with non-institutional claims with “GW” modifier.

- The average number of hospice beneficiaries per non-hospice provider with Part D claims.

To calculate the average number of hospice beneficiaries per non-hospice provider, we count the number of unique beneficiaries associated with each non-hospice provider as beneficiaries may receive services by more than one non-hospice provider. This means that some beneficiaries are double-counted. However, given this estimate is calculated based on the number of expected communication encounters between hospices and non-hospice providers, this is the appropriate approach. Because we double-counted beneficiaries, we expect that average to be larger than the ratio of unique beneficiaries to unique non-hospice providers. Table 22 below summarizes Part A, B and D claims that overlap with hospice episodes in FY 2017.

TABLE 22—SUMMARY OF PART A, B AND D CLAIMS THAT OVERLAP WITH HOSPICE EPISODES, FY 2017

| Non-hospice claim type | Number of hospice beneficiaries | Number of non-hospice providers | Number of hospice providers | Average number of hospice benes per non-hospice provider |
|-------------------------------------|---------------------------------|---------------------------------|-----------------------------|--|
| Part A & B, Non-Hospice Total | 473,587 | 94,535 | 4,341 | |

TABLE 22—SUMMARY OF PART A, B AND D CLAIMS THAT OVERLAP WITH HOSPICE EPISODES, FY 2017—Continued

| Non-hospice claim type | Number of hospice beneficiaries | Number of non-hospice providers | Number of hospice providers | Average number of hospice beneficiaries per non-hospice provider |
|------------------------------------|---------------------------------|---------------------------------|-----------------------------|--|
| Institutional Claims w/07 | 173,060 | 19,354 | 4,117 | 11.0 |
| Non-Institutional Lines w/GW | 431,379 | 75,181 | 4,321 | 12.0 |
| Part D | 591,543 | 60,632 | 4,416 | 12.0 |

Source: FY 2017 Parts A, B, and D claims.

3. Burden Estimate Without Election Statement Addendum for Non-Hospice Providers

In order for non-hospice providers to make treatment decisions regarding services, items and medications for hospice beneficiaries and to submit the appropriate modifier or condition code on Medicare claims, they need supporting information from the hospice regarding related and unrelated conditions. As such, we first estimate the current burden associated with this communication and coordination in the absence of the election statement addendum. We believe this would require the non-hospice providers to contact the hospice and have a detailed phone call to obtain and document the information on unrelated conditions, items, services, and medications. For non-hospice providers submitting institutional claims (including inpatient acute care hospitals, SNFs, HHAs, and institutional outpatient providers), typically nurse case managers provide coordination of care for those beneficiaries in these settings who are receiving inpatient services or who are preparing to transition to a post-acute care setting or home. The estimated burden for the registered nurse to contact the hospice to obtain the needed information would be 15 minutes ($15/60 = 0.25$). The average number of hospice beneficiaries receiving services per institutional, non-hospice provider is 11 per year, which would mean each institutional, non-hospice provider would have an average of 11 communication encounters with hospice. The total number of institutional, non-hospice providers servicing hospice beneficiaries in FY 2017 was 19,354. At \$70.72 per hour for a registered nurse ($0.25 \times \$70.72$) = \$17.68, we estimate the total cost per institutional, non-hospice provider furnishing services to hospice beneficiaries in FY 2020 to be ($\$17.68 \times 11$) = \$194.48 and the annual total cost for all institutional, non-hospice providers in FY 2018 would be ($\$194.48 \times 19,354$) = \$3,763,966.

For non-institutional, non-hospice providers (including physicians), we

also expect that a nurse would contact the hospice to obtain the needed clinical information on unrelated conditions, items, services and drugs. The estimated burden for the registered nurse to contact the hospice to obtain the needed information would be 15 minutes ($15/60 = 0.25$). The average number of hospice beneficiaries receiving services per non-institutional, non-hospice provider is 12 per year, which would mean each provider would have an average of 12 communication encounters with a hospice. The total number of non-institutional, non-hospice providers servicing hospice beneficiaries in FY 2017 was 75,181. At \$70.72 per hour for a registered nurse ($0.25 \times \$70.72$) = \$17.68, we estimate the total cost per non-institutional, non-hospice provider furnishing services to hospice beneficiaries in FY 2020 to be ($\$17.68 \times 12$) = \$212.16 and the annual total cost for all non-institutional, non-hospice providers in FY 2018 would be ($\$212.16 \times 75,181$) = \$15,950,401.

For Part D providers furnishing drugs to hospice beneficiaries, the estimated burden for the pharmacy technician at the point of service to contact the hospice to obtain the needed clinical information regarding the drugs deemed by the hospice as unrelated to the terminal illness and related conditions would be 15 minutes ($15/60 = 0.25$). The average number of hospice beneficiaries receiving services per Part D pharmacy providing maintenance drugs is 12 per year, which would mean each pharmacy would have an average of 12 communication encounters with hospice. The total number of Part D pharmacies providing maintenance drugs to hospice beneficiaries in FY 2017 was 60,632. At \$31.80 per hour for a pharmacy technician ($0.25 \times \$31.80$) = \$7.95, we estimate the total cost per Part D pharmacy providing maintenance drugs to be ($\$7.95 \times 12$) = \$95.40 and the annual total cost for all Part D pharmacies providing maintenance drugs to be ($\$95.40 \times 60,632$) = \$5,784,293. The estimated total annual burden for all non-hospice providers furnishing services, items and medications to hospice beneficiaries in

FY 2020 without the availability of the hospice election statement addendum identifying unrelated conditions, items, services and drugs would be \$25,498,660 (\$3,763,966 + \$15,950,401 + \$5,784,293).

4. Burden Reduction Estimate With Election Statement Addendum for Non-Hospice Providers

However, with the availability of the “Patient Notification of Hospice Covered/Non-Covered Items, Services, and Drugs” election statement addendum, we believe this estimated burden would be reduced for non-hospice providers through a streamlining of the communication and coordination process. For institutional, non-hospice providers (those who would submit claims for unrelated services with condition code 07), the estimated burden for the registered nurse to contact the hospice to obtain the needed information would be reduced to 5 minutes ($5/60 = 0.0833$). The average number of hospice beneficiaries receiving services per institutional non-hospice provider is 11 per year. The total number of institutional non-hospice providers servicing hospice beneficiaries in FY 2017 was 19,354. At \$70.72 per hour for a registered nurse ($0.0833 \times \$70.72$) = \$5.89, we estimate the total cost per institutional non-hospice provider in FY 2020 to be ($\$5.89 \times 11$) = \$64.79 and the annual total cost for all institutional non-hospice providers in FY 2020 would be ($\$64.79 \times 19,354$) = \$1,253,945.66 an annual decrease in burden by ($\$3,763,966 - \$1,253,945.66$) = \$2,510,020.34.

For non-institutional, non-hospice providers (those who would submit claims for unrelated services with modifier GW), the estimated burden for the registered nurse to contact the hospice to obtain the needed information would be reduced to 5 minutes ($5/60 = 0.0833$). The average number of hospice beneficiaries receiving services per non-institutional, non-hospice provider is 12 per year. The total number of non-institutional, non-hospice providers servicing hospice

beneficiaries in FY 2017 was 75,181. At \$70.72 per hour for a registered nurse ($0.0833 \times \$70.72 = \5.89), we estimate the total cost per non-institutional, non-hospice provider in FY 2020 to be ($\$5.89 \times 12$) = \$70.68 and the annual total cost for all non-institutional, non-hospice providers in FY 2020 would be ($\$70.68 \times 75,181$) = \$5,313,793.08, an annual decrease in burden by ($\$15,950,401 - 5,313,793.08$) = \$10,636,607.92.

For Part D pharmacies providing drugs to hospice beneficiaries, the estimated burden for the pharmacy technician at the point of service to contact the hospice to obtain the needed clinical information regarding the drugs

deemed by the hospice as unrelated to the terminal illness and related conditions would be reduce to 5 minutes ($5/60 = 0.0833$). The average number of hospice beneficiaries receiving services per Part D pharmacy providing maintenance drugs is 12 per year. The total number of Part D pharmacies providing maintenance drugs to hospice beneficiaries in FY 2017 was 60,632. At \$31.80 per hour for a pharmacy technicians ($0.0833 \times \$31.80$) = \$2.65, we estimate the total cost per Part D pharmacy providing maintenance drugs to be ($\$2.65 \times 12$) = \$31.80 and the annual total cost for all Part D pharmacies providing maintenance drugs to be ($\$31.80 \times$

60,632) = \$1,928,097.60, an annual decrease in burden by ($\$5,784,293 - \$1,928,097.60$) = \$3,856,195.40. The estimated total annual burden for all non-hospice providers furnishing services, items and drugs to hospice beneficiaries in FY 2020 with the availability of the hospice election statement addendum identifying unrelated conditions, items, services and medication would be \$8,495,836.66 for an overall burden reduction of ($\$25,498,660 - \$8,495,836.66$) = \$17,002,823.34. The total reduction in burden for all institutional, non-institutional, and Part D pharmacy non-hospice providers is summarized in table 23 below.

TABLE 23—FY 2020 ESTIMATED TOTAL OVERALL BURDEN REDUCTION FOR NON-HOSPICE PROVIDERS USING ELECTION STATEMENT ADDENDUM

| Non-hospice claims | Burden without addendum | Burden with addendum | Estimated burden reduction for non-hospice providers |
|--|-------------------------|----------------------|--|
| Institutional Claims with Condition Code 07 | \$3,763,966 | \$1,253,945 | \$2,510,021 |
| Non-institutional Claims with GW Modifier | 15,950,401 | 5,313,793 | 10,636,608 |
| Part D Maintenance Drugs | 5,784,293 | 1,928,098 | 3,856,195 |
| Total Burden Reduction for Non-Hospice Providers | 25,498,660 | 8,495,836 | 17,002,824 |

The use of the “Patient Notification of Hospice Non-Covered Items, Services, and Drugs” election statement

addendum would result in an estimated, total overall provider burden reduction of –\$4,224,173 (\$12,778,651 –

\$17,002,824) in FY 2020. Table 24 below summarizes the FY 2020 estimated total burden reduction.

TABLE 24—FY 2020 ESTIMATED TOTAL PROVIDER BURDEN REDUCTION USING ELECTION STATEMENT ADDENDUM

| | |
|---|----------------|
| FY 2020 Estimated Cost for Election Statement Addendum | + \$12,778,651 |
| FY 2020 Estimated Non-hospice Provider Burden Reduction | – 7,002,824 |
| FY 2020 Estimated Total Burden Reduction | (4,224,173) |

B. Submission of PRA-Related Comments

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

To obtain copies of the supporting statement and any related forms for the proposed collections previously discussed, visit our website at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html>, or call the Reports Clearance Office at (410) 786–1326.

We invite public comments on these information collection requirements. If you wish to comment, submit your comments electronically as specified in the **DATES** and **ADDRESSES** sections of

this proposed rule and identify the rule (CMS–1714–P) and, where applicable, indicate the ICR’s CFR citation, CMS ID number, and OMB control number.

V. Response to Comments

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

VI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule meets the requirements of our regulations at

§ 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of Core-Based Statistical Areas (CBSAs) or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This proposed rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2020 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. Lastly, section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices, and this

rule discusses changes in the requirements for the hospice quality reporting program in accordance with section 1814(i)(5) of the Act.

B. Overall Impacts

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an estimated increase of \$540 million in payments to hospices, resulting from the hospice payment update percentage of 2.7 percent for FY 2020. Section 1814(i)(6)(D)(ii) of the Act requires the proposed rebasing of the per diem payment rates for CHC, GIP, and IRC to be done in a budget-neutral manner in the first year of implementation. Therefore, the proposed rebased rates for CHC, GIP, and IRC would not result in an overall payment impact for the Medicare program as we are proposing to reduce the RHC payment rates to ensure that total estimated payments to hospices are budget-neutral given the proposed increases to the CHC, GIP, and IRC payment rates. In addition, the proposed change in the hospice wage index to use the FY 2020 pre-floor, pre-reclassified hospital wage index (rather than the FY 2019 pre-floor, pre-reclassified hospital wage index) as the basis for the FY 2020 hospice wage index would not result in an overall payment impact for the Medicare program as annual wage index updates are now similarly implemented in a budget-neutral manner. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and

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

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

C. Anticipated Effects

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than \$7.5 million to \$38.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. HHS’s practice in interpreting the RFA is to consider effects economically “significant” only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The effect of the FY 2020 hospice payment update percentage results in an overall increase in

estimated hospice payments of 2.7 percent, or \$540 million. The distributional effects of the proposed FY 2020 hospice wage index do not result in a greater than 5 percent of hospices experiencing decreases in payments of 3 percent or more of total revenue. Finally, the distributional effects of the proposed FY 2020 increases to the CHC, IRC, and GIP per diem payment rates as a result of rebasing, offset by a proposed decrease to the FY 2020 RHC payment rates of less than 3 percent to maintain budget neutrality in the first year of implementation, do not result in a greater than 5 percent of hospices experiencing decreases in payments of 3 percent or more of total revenue. Therefore, the Secretary has determined that this rule will not create a significant economic impact on a substantial number of small entities.

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

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. The 2019 UMRA threshold is \$154 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of \$154 million or more.

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

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

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

Using the wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is \$107.38 per hour, including overhead and fringe benefits (https://www.bls.gov/oes/current/oes_nat.htm). This proposed rule consists of approximately 43,000 words. Assuming an average reading speed of 250 words per minute, it would take approximately one and a half hour for the staff to review half of it. For each hospice that reviews the rule, the estimated cost is \$153.55 (1.43 hour \times \$107.38). Therefore, we estimate that the total cost of reviewing this regulation is \$18,733.10 (\$153.55 \times 122 reviewers).

D. Detailed Economic Analysis

1. Hospice Payment Update for FY 2020

The FY 2020 hospice payment impacts appear in table 24. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size), and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows our estimate of applying the proposed rebased payment rates of CHC, IRC, and GIP (and the decreased RHC rate used to achieve budget neutrality). The fourth column shows the hospice payments using FY 2018 Hospice Claims, FY 2020 rebased Payments, and FY 2020 Wage Index without the 1-Year lag. The fifth column show the proposed FY 2020 hospice payment update percentage of 2.7 percent as mandated by section 1814(i)(1)(C) of the Act, and is consistent for all providers. The 2.7 percent hospice payment update percentage is based on an estimated 3.2 percent inpatient hospital market basket update, reduced by a 0.5 percentage point productivity adjustment. It is projected that aggregate payments would increase by 2.7 percent, assuming

hospices do not change their service and billing practices. The sixth column shows the estimated total impact for FY 2020. We have set the rates so the overall impact is zero percent due to the requirement that any revisions in payment are implemented in a budget-neutral manner in accordance with section 1814(i)(6)(D)(ii) of the Act (accomplished for the proposed rebasing of the CHC, GIP, and IRC payment rates by a corresponding proposed decrease to the RHC payment rates).

In addition, to assist providers in understanding the potential impacts of the proposed wage index with and without the lag and the proposed rebasing of CHC, IRC, and GIP, we are providing a provider-specific impact analysis file, which is available on our website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices.html>. We note that simulated payments are based on utilization in FY 2018 as seen on Medicare hospice claims (accessed from the CCW in January of 2019) and only include payments related to the level of care and do not include payments related to the service intensity add-on.

As illustrated in table 25, the combined effects of all the proposals vary by specific types of providers and by location.

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Table 25: Projected Impact to Hospices for FY 2020

| | Hospices | Proposed Rebasing of CHC, IRC, and GIP | FY 2020 Updated Wage Data Without the 1 Year Lag | Proposed FY 2020 Hospice Payment Update Percentage | Estimated Total Impact for FY 2020 |
|--|----------|--|--|---|---|
| All Hospices | 4,569 | 0.0% | 0.0% | 2.7% | 2.7% |
| Hospice Type and Control | | | | | |
| Freestanding/Non-Profit | 601 | 1.4% | 0.1% | 2.7% | 4.2% |
| Freestanding/For-Profit | 2,819 | -0.8% | -0.1% | 2.7% | 1.8% |
| Freestanding/Government | 39 | 0.0% | -0.3% | 2.7% | 2.4% |
| Freestanding/Other | 322 | 0.2% | 0.1% | 2.7% | 3.0% |
| Provider/HHA-Based/Non-Profit | 396 | 0.7% | 0.0% | 2.7% | 3.4% |
| Provider/HHA-Based/For-Profit | 194 | -1.3% | 0.0% | 2.7% | 1.4% |
| Provider/HHA-Based/Government | 101 | 0.4% | 0.2% | 2.7% | 3.3% |
| Provider/HHA-Based/Other | 97 | 0.6% | 0.0% | 2.7% | 3.3% |
| Subtotal: Freestanding Provider Type | 3,781 | 0.0% | 0.0% | 2.7% | 2.7% |
| Subtotal: Provider/HHA Based Provider Type | 788 | 0.2% | 0.0% | 2.7% | 2.9% |
| Subtotal: Non-Profit | 997 | 1.3% | 0.1% | 2.7% | 4.1% |
| Subtotal: For Profit | 3,013 | -0.8% | -0.1% | 2.7% | 1.8% |
| Subtotal: Government | 140 | 0.2% | -0.1% | 2.7% | 2.8% |
| Subtotal: Other | 419 | 0.3% | 0.1% | 2.7% | 3.1% |
| Hospice Type and Control: Rural | | | | | |
| Freestanding/Non-Profit | 154 | 0.4% | 0.5% | 2.7% | 3.6% |
| Freestanding/For-Profit | 328 | -1.7% | 0.2% | 2.7% | 1.2% |
| Freestanding/Government | 20 | -0.8% | 0.0% | 2.7% | 1.9% |
| Freestanding/Other | 45 | -1.3% | 0.2% | 2.7% | 1.6% |
| Provider/HHA-Based/Non-Profit | 157 | 0.6% | 0.0% | 2.7% | 3.3% |
| Provider/HHA-Based/For-Profit | 47 | -1.6% | 0.1% | 2.7% | 1.2% |
| Provider/HHA-Based/Government | 74 | -0.7% | 0.3% | 2.7% | 2.3% |
| Provider/HHA-Based/Other | 54 | -0.5% | 0.5% | 2.7% | 2.7% |
| Hospice Type and Control: Urban | | | | | |
| Freestanding/Non-Profit | 447 | 1.5% | 0.1% | 2.7% | 4.3% |
| Freestanding/For-Profit | 2,491 | -0.7% | -0.1% | 2.7% | 1.9% |
| Freestanding/Government | 19 | 0.1% | -0.3% | 2.7% | 2.5% |
| Freestanding/Other | 277 | 0.3% | 0.1% | 2.7% | 3.1% |
| Provider/HHA-Based/Non-Profit | 239 | 0.7% | 0.0% | 2.7% | 3.4% |
| Provider/HHA-Based/For-Profit | 147 | -1.3% | 0.0% | 2.7% | 1.4% |
| Provider/HHA-Based/Government | 27 | 1.4% | 0.1% | 2.7% | 4.2% |

| | | | | | |
|--|-------|-------|-------|------|-------|
| Provider/HHA-Based/Other | 43 | 0.9% | -0.1% | 2.7% | 3.5% |
| Hospice Location: Urban or Rural | | | | | |
| Rural | 879 | -0.8% | 0.2% | 2.7% | 2.1% |
| Urban | 3,690 | 0.1% | 0.0% | 2.7% | 2.8% |
| Hospice Location: Region of the Country (Census Division) | | | | | |
| New England | 157 | 0.0% | -0.5% | 2.7% | 2.2% |
| Middle Atlantic | 281 | 0.2% | -0.1% | 2.7% | 2.8% |
| South Atlantic | 554 | 2.0% | 0.0% | 2.7% | 4.7% |
| East North Central | 543 | 0.1% | 0.0% | 2.7% | 2.8% |
| East South Central | 263 | -0.4% | 0.1% | 2.7% | 2.4% |
| West North Central | 404 | -1.4% | 0.6% | 2.7% | 1.9% |
| West South Central | 875 | -0.5% | 0.1% | 2.7% | 2.3% |
| Mountain | 458 | -0.6% | 0.2% | 2.7% | 2.3% |
| Pacific | 988 | -1.5% | -0.2% | 2.7% | 1.0% |
| Outlying | 46 | -2.7% | -0.3% | 2.7% | -0.3% |
| Hospice Size | | | | | |
| 0 - 3,499 RHC Days (Small) | 971 | -1.0% | 0.0% | 2.7% | 1.7% |
| 3,500-19,999 RHC Days (Medium) | 2,130 | -1.1% | 0.0% | 2.7% | 1.6% |
| 20,000+ RHC Days (Large) | 1,468 | 0.3% | 0.0% | 2.7% | 3.0% |

Source: FY 2018 hospice claims data as of December 31, 2018 from the CCW RIFs, accessed January 2019.

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

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2. Proposed Hospice Election Statement Addendum

This proposed rule includes proposals related to the election statement addendum that would be provided, upon request, to hospice beneficiaries (or representative), non-hospice providers, and Medicare contractors. If finalized, this change would become effective for hospice elections on and after October 1, 2019. The election statement addendum would add no additional burden for communicating with non-hospice providers, as this decision-making process has been a long-standing CoP requirement, as described in the preamble of this proposed rule. However, burden would be reduced for non-hospice providers, including institutional, non-institutional and pharmacy providers

because less time would be spent trying to obtain needed information for treatment decisions and accurate claims submissions. As a result of this election statement addendum, we estimate that this rule generates \$4.2 million in annualized cost savings, or \$3 million per year on an ongoing basis discounted at 7 percent relative to year 2016, over a perpetual time horizon beginning in FY 2020. The burden reduction for this proposal is detailed in section IV of this proposed rule and the total annual reduction is included in table 24.

E. Alternatives Considered

For the FY 2020 Hospice Wage Index and Rate Update proposed rule, we considered alternatives to the proposals articulated in section III.A. First, we considered not applying the Level I edits to the freestanding cost reports to

estimate the FY 2017 costs per day by level of care. Our analysis showed that the differences in costs for each level of care between these two approaches were minimal. As described in the FY 2019 hospice proposed rule (89 FR 20949), industry representatives have suggested using these Level I edits to force adherence to certain cost reporting principles that could lead to the reporting of higher-quality hospice cost data and therefore, we believe it is most technically appropriate to apply the Level I edits. Table 26 describes the FY 2017 estimated, average per day costs by level of care applying all cost report adjustments, and those same estimated costs applying all cost report adjustments except the Level I edits.

TABLE 26—FREESTANDING HOSPICE AVERAGE PER DAY COSTS WITHOUT LEVEL I EDITS, FY 2017

| Level of care | Estimated average cost per day using all adjustments | Estimated average cost per day using all adjustments, except Level I edits |
|-----------------------|--|--|
| RHC (Days 1–60) | \$164.89 | \$164.17. |
| RHC (Days 61+) | \$114.11 | \$113.62. |
| CHC | \$54.49 (\$1,307.76 for 24 hours) | \$53.83 (\$1,291.92 for 24 hours). |
| IRC | \$438.97 | \$467.78. |
| GIP | \$953.95 | \$960.12. |

We also considered proposing to use freestanding and provider-based cost reports to rebase CHC, IRC, and GIP per diem rates, rather than using only freestanding hospice cost reports. When

we analyzed both freestanding and provider-based cost reports, the results from these two samples tend to be similar, however, on average, incorporating provider-based cost

reports results in higher costs than the cost reports for freestanding hospices only as shown in table 27.

TABLE 27—FREESTANDING AND PROVIDER-BASED AVERAGE COST PER DAY BY LEVEL OF CARE, FY 2017

| Level of care | Freestanding average cost per day | Provider-based average cost per day |
|-----------------------|---|-------------------------------------|
| RHC (Days 1–60) | \$164.89 | \$169.36. |
| RHC (Days 61+) | \$114.11 | \$117.21. |
| CHC | \$54.49 (\$1,307.76 for 24 hours) | \$56.20 (\$1,348.80 for 24 hours). |
| IRC | \$438.98 | \$521.74. |
| GIP | \$953.96 | \$956.04. |

—With all cost report adjustments applied.
—With Level I Edits.

Since the costs are higher, the FY 2019 rebased payment rates for CHC, GIP, and IRC when using cost reports for both freestanding and provider-based hospices would also be higher and we

would need to reduce the RHC payment more in order to maintain budget neutrality as shown in table 28. If we utilized freestanding and provider-based cost reports, RHC would need to be

reduced by 2.92 percent to offset the increases to the per diem payment amounts for CHC, GIP, and IRC.⁴⁹

TABLE 28—REBASED PAYMENT RATES FOR CHC, IRC, AND GIP LEVELS OF CARE USING FREESTANDING AND PROVIDER-BASED HOSPICE COST REPORTS, FY 2019

| Level of care | Rebased payment rates |
|------------------------------------|--|
| Continuous Home Care (CHC) | \$58.59 per hour/\$1,406.04 (per day). |
| Inpatient Respite Care (IRC) | \$517.98.* |
| General Inpatient Care (GIP) | \$996.62. |

Note:

—Prior to application of the hospice payment update percentage of 2.7 percent outlined in section III.B.4 of this proposed rule.

—Includes Level I edits.

*IRC payment rate accounts for 5 percent coinsurance (\$543.88 / 1.05 = \$517.98).

In MedPAC's March 2018 Report to Congress, MedPAC stated that included in the costs of provider-based hospices are overhead costs allocated from the parent provider, which contributes to provider-based hospices having higher costs than freestanding providers. The Commission believes payment policy should focus on the efficient delivery of services to Medicare's beneficiaries. If freestanding hospices are able to provide high-quality care at a lower cost than provider-based hospices, payment rates should be set accordingly, and the

higher costs of provider-based hospices should not be a reason for increasing Medicare payment rates.⁵⁰ Similarly, the application of the cost report exclusions yielded a small sample size of provider-based cost reports and when we applied the Level I cost report edits to the provider-based cost reports, this trimmed out nearly all of the provider-based cost reports. Therefore, we are less confident in the calculations of the average costs per day by level of care using provider-based hospice cost reports as very few of such providers

had costs reports that were not trimmed out due to the recently implemented Level I cost report edits. We invite comments on the alternatives considered discussed in this analysis.

F. Accounting Statement

As required by OMB Circular A–4 (available at: <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf>), in table 29, we have prepared an accounting statement showing the classification of the transfers and costs

⁴⁹ Using the average per-diem costs generated from our sample of freestanding and provider-based hospice cost reports, rebasing CHC, IRC, and GIP results in extra payments of \$503,162,283.48 for those levels of care. The RHC payments that were made under the payment rates in place during FY

2019 were \$17,218,209,794.15. One minus the value of the extra payments over the RHC payments equals 0.9708.

⁵⁰ Medicare Payment Advisory Commission (MedPAC). "Hospice Services." *Report to the*

Congress: Medicare Payment Policy. Washington, DC. March 2018. P. 341. http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch12_sec.pdf?sfvrsn=0.

associated with the provisions of this proposed rule. This table shows an estimated \$540 million in transfers to hospices in FY 2020. All expenditures are classified as transfers to hospices. Table 29 also reflects the estimated change in costs and burden for hospices and non-hospice providers as a result of the proposed election statement addendum requirements described in

section III.C. Table 29 provides our best estimate of a one-time burden for hospices to develop the election statement addendum form of 2,233 hours or \$196,281, as well as our estimate of the annual burden for hospices to complete the election statement addendum of 744 hours or \$12.6 million for an estimated total burden for hospices of \$12.8 million, as

described in section IV of this proposed rule. Additionally, we estimate a net reduction in burden for non-hospice providers of 25,866 hours or \$17 million (see section IV of this proposed rule) for an estimated overall, annualized net reduction in burden with the proposed election statement addendum of \$4.2 million.

TABLE 29—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM FY 2019 TO FY 2020

| Category | Transfers |
|---|--|
| Annualized Monetized Transfers | \$ 540 million.* |
| From Whom to Whom? | Federal Government to Medicare Hospices. |
| Category | Costs |
| Annualized Monetized Net Reduction in Burden for Non-Hospice Providers with the Proposed Regulations Change at \$418.24, Election Statement Addendum. | –\$17.0 million. |
| Annualized Net Burden for Hospice Providers with the One-time Form Development and Completion of Election Statement Addendum. | +\$12.8 million. |
| Total Annualized Net Reduction In Burden with the Proposed Election Statement Addendum | –\$4.2 million. |

*The net increase of \$540 million in transfer payments is a result of the 2.7 percent hospice payment update compared to payments in FY 2019.

G. Regulatory Reform Analysis Under E.O. 13771

Executive Order 13771, entitled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017 (82 FR 9339, February 3, 2017) and requires that the costs associated with significant new regulations “shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.” This proposed rule is expected to be an E.O. 13771 deregulatory action with \$4.2 million in annualized cost savings, or \$3 million per year on an ongoing basis discounted at 7 percent relative to year 2016, over a perpetual time horizon beginning in FY 2020. The burden reduction for this proposal is detailed in section IV of this proposed rule and the total annual reduction is included in Table 24. Details on the estimated cost savings of this rule with comment period can be found in the rule’s collection of information and economic analysis.

H. Conclusion

We estimate that aggregate payments to hospices in FY 2020 will increase by \$540 million, or 2.7 percent, compared to payments in FY 2019. We estimate that in FY 2020, hospices in urban and rural areas will experience, on average, 2.8 percent and 2.1 percent increases, respectively, in estimated payments compared to FY 2019. Hospices providing services in the South Atlantic,

Middle Atlantic and East North Central regions would experience the largest estimated increases in payments of 4.7 percent and 2.8 percent, respectively. Hospices serving patients in the Pacific and outlying regions would experience, on average, the lowest estimated increase of 1.0 and –0.3 percent, respectively in FY 2020 payments. We also estimate an overall reduction in burden of \$4.2 million as a result of the proposed election statement addendum. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 418

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

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

PART 418—HOSPICE CARE

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

Authority: 42 U.S.C. 1302 and 1395hh.

- 2. Section 418.24 is amended by—
- a. Revising paragraphs (b)(2) and (3);
- b. Redesignating paragraph (b)(5) as paragraph (b)(8);
- c. Adding new paragraphs (b)(5), (6), and (7);
- d. Redesignating paragraphs (c) through (f) as paragraphs (d) through (g), respectively; and

■ e. Adding a new paragraph (c).

The revisions and additions read as follows:

\$418.24 Election of hospice care.

* * * * *

(b) * * *

(2) The individual’s or representative’s acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual’s terminal illness and related conditions.

(3) Acknowledgement that the individual has been provided information on the hospice’s coverage responsibility and that certain Medicare services, as set forth in paragraph (e) of this section, are waived by the election. This includes providing the individual with information indicating that services unrelated to the terminal illness and related conditions are exceptional and unusual and hospice should be providing virtually all care needed by the individual who has elected hospice.

* * * * *

(5) Information on individual cost-sharing for hospice services.

(6) Notification of the individual’s (or representative’s) right to receive an election statement addendum, as set forth in paragraph (c) of this section, if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual’s terminal illness and related conditions and would not be covered by the hospice.

(7) Information on BFCC-QIO, including the right to immediate advocacy and BFCC-QIO contact information.

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(c) *Content of hospice election statement addendum.* In the event that the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the election statement. If the election statement addendum is requested at the time of hospice election, the hospice must provide this information, in writing, to the individual (or representative) within 48 hours. If this addendum is requested during the course of the hospice election, the hospice must provide this information, in writing, immediately to the requesting individual (or representative), non-hospice provider, or Medicare contractor. If there are any changes to the content on the addendum during the course of the hospice election, the hospice must update the addendum and provide these updates, in writing, to the individual (or representative). The election statement addendum must include the following:

(1) The addendum must be titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs."

(2) Name of the hospice.

(3) Individual's name and hospice medical record identifier.

(4) Identification of the individual's terminal illness and related conditions.

(5) A list of the individual's conditions present on hospice admission (or upon plan of care update) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions.

(6) A written clinical explanation, in language the individual (or representative) can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the individual's terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation must be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs are related is made for each patient and that the individual should share this clinical explanation with other health care providers from which they seek items, services, or drugs unrelated to their terminal illness and related conditions.

(7) References to any relevant clinical practice, policy, or coverage guidelines.

(8) Information on the following—

(i) *Purpose of addendum.* The purpose of the addendum is to notify the individual (or representative), in

writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions.

(ii) *Right to immediate advocacy.* The addendum must include language that immediate advocacy is available through the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if the individual (or representative) disagrees with the hospice's determination.

(9) Name and signature of the individual (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the individual's (or representative's) agreement with the hospice's determinations.

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Dated: April 4, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 9, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

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