FEDERAL REGISTER

Vol. 80 Tuesday,
No. 86 May 5, 2015

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 418

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1629–P]

RIN 0938–AS39

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

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

ACTION: Proposed rule.

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

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 29, 2015.

ADDRESSES: In commenting, please refer to file code CMS–1629–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

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

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1629–P, P.O. Box 8010, Baltimore, MD 21244–8010.

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

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

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1629–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

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

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

SUPPLEMENTARY INFORMATION:

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

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

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

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Acronyms

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

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

I. Executive Summary for This Proposed Rule

A. Purpose

This rule proposes updates to the payment rates for hospices for fiscal year (FY) 2016, as required under section 1814(i) of the Social Security Act (the Act) and reflects the final year of the 7-year Budget Neutrality Adjustment Factor (BNAF) phase-out finalized in the FY 2010 Hospice Wage Index final rule (74 FR 39407). Our proposed update to payment rates for hospices also includes a proposal to

change the hospice wage index by incorporating the new Office of Management and Budget (OMB) core-based statistical area (CBSA) definitions, changes to the aggregate cap calculation required by section 1814(i)(2)(B)(ii) of the Act, and includes a proposal to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the federal fiscal year starting in FY 2017. In addition, in accordance with section 1814(i)(6)(D)(i) of the Act, this rule proposes to create two different payment rates for routine home care (RHC) that would result in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate days 61 or over of hospice care. Also, in accordance with section 1814(i)(6)(d)(i) of the Act, this rule proposes a service intensity add-on (SIA) payment that would result in an add-on payment equal to the Continuous Home Care (CHC) hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse (RN) or social worker provided during the last 7 days of a beneficiary's life, if certain criteria are met. In addition, section 3004(c) of the Affordable Care Act established a quality reporting program for hospices. In accordance with section 1814(i)(5)(A) of the Act, starting in FY 2014, hospices that have failed to meet quality reporting requirements receive a 2 percentage point reduction to their payment update percentage. Although this proposed rule does not propose new quality measures, it provides updates on the hospice quality reporting program. Finally, this proposed rule includes a clarification regarding diagnosis reporting on the hospice claim form.

B. Summary of the Major Provisions

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

In section III.C.1 of this rule, we propose to update the hospice wage index using a 50/50 blend of the existing CBSA designations and the new CBSA designations outlined in a February 28, 2013, OMB bulletin. Section III.C.2 of this rule implements year 7 of the 7-year BNAF phase-out finalized in the FY 2010 Hospice Wage Index final rule (74 FR 39407). In section III.C.3, we propose to update the hospice payment rates for FY 2016 by 1.8 percent. Section III.C.4 would implement changes mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), in which the aggregate cap for accounting years that end after September 30, 2016 and before October 1, 2025, would be updated by the hospice payment update rather than using the CPI–U. Specifically, the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016, would be updated by the FY 2016 percentage update for hospice care. In addition, in section III.D, we are proposing to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the fiscal year for FY 2017 and later. We believe that this would allow for the timely implementation of the IMPACT Act changes while better aligning the cap accounting year with the timeframe described in the IMPACT Act.

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

C. Summary of Impacts

TABLE 1—IMPACT SUMMARY TABLE

Provision description	Transfers
FY 2016 Hospice Wage Index and Payment Rate Update.	The overall economic impact of this proposed rule is estimated to be $200 million in increased payments to hospices during FY 2016.

II. Background

A. Hospice Care

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

Medicare regulations define ''palliative care'' as ''patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.'' (42 CFR 418.3) Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit. *See also* Hospice Conditions of Participation final rule (73 FR 32088) (2008). The goal of palliative care in hospice is to improve the quality of life of individuals, and their families, facing the issues associated with a life-threatening illness through the

prevention and relief of suffering by means of early identification, assessment and treatment of pain and other issues. This is achieved by the hospice interdisciplinary team working with the patient and family to develop a comprehensive care plan focused on coordinating care services, reducing unnecessary diagnostics or ineffective therapies, and offering ongoing conversations with individuals and their families about changes in their condition. It is expected that this comprehensive care plan will shift over time to meet the changing needs of the patient and family as the individual approaches the end of life.

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

The goal of hospice care is to make the hospice patient as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment. Hospice care uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through the use of a broad spectrum of professional and other caregivers and volunteers. While the goal of hospice care is to allow for the individual to remain in his or her home environment, circumstances during the end-of-life may necessitate short-term inpatient admission to a hospital, skilled nursing facility (SNF), or hospice facility for procedures necessary for pain control or acute or chronic symptom management that cannot be managed in any other setting. These acute hospice care services are to ensure that any new or worsening symptoms are intensively addressed so that the individual can return to his or her home environment at a home level of care. Short-term, intermittent, inpatient respite services are also available to the family of the hospice patient when needed to relieve the family or other caregivers. Additionally, an individual can receive continuous home care during a period of crisis in which an individual requires primarily continuous nursing care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. Continuous home care may be covered on a continuous basis for as much as 24 hours a day, and these periods must be predominantly nursing care in accordance with our regulations at § 418.204. A minimum of 8 hours of nursing, or nursing and aide, care must be furnished on a particular day to qualify for the continuous home care rate (§ 418.302(e)(4)).

Hospices are expected to comply with all civil rights laws, including the provision of auxiliary aids and services to ensure effective communication with patients or patient care representatives with disabilities consistent with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, and to provide language access for such persons who are limited in English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at *http://www.hhs.gov/ocr/civilrights*.

B. History of the Medicare Hospice Benefit

Before the creation of the Medicare hospice benefit, hospice programs were originally operated by volunteers who cared for the dying. During the early development stages of the Medicare hospice benefit, hospice advocates were clear that they wanted a Medicare benefit that provided all-inclusive care for terminally-ill individuals, provided pain relief and symptom management, and offered the opportunity to die with dignity in the comfort of one's home rather than in an institutional setting.[1]

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

As stated in the August 22, 1983 proposed rule entitled ''Medicare Program; Hospice Care'' (48 FR 38146), ''the hospice experience in the United States has placed emphasis on home care. It offers physician services, specialized nursing services, and other forms of care in the home to enable the terminally ill individual to remain at home in the company of family and friends as long as possible.'' The concept of a patient ''electing'' the hospice benefit and being certified as terminally ill were two key components of the legislation responsible for the creation of the Medicare Hospice Benefit (section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), (Pub. L. 97–248)). Section 122 of TEFRA created the Medicare Hospice benefit, which was implemented on November 1, 1983. Under sections 1812(d) and 1861(dd) of the Act, codified at 42 U.S.C. 1395d(d) and 1395x(dd), we provide coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a Medicare-certified hospice. Our regulations at § 418.54(c) stipulate that the comprehensive hospice assessment must identify the patient's physical, psychosocial, emotional, and spiritual needs related to the terminal illness and related conditions, and address those needs in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors: The nature and condition causing admission (including the presence or lack of objective data and subjective complaints); complications and risk factors that affect care planning; functional status; imminence of death; and severity of symptoms (§ 418.54(c)). The Medicare hospice benefit requires the hospice to cover all reasonable and necessary palliative care related to the terminal prognosis, as described in the patient's plan of care. The December 16, 1983 Hospice final rule (48 FR 56008) requires hospices to cover care for interventions to manage pain and symptoms. Additionally, the hospice Conditions of Participation (CoP) at § 418.56(c) require that the hospice must provide all reasonable and necessary services for the palliation and management of the terminal illness, related conditions and interventions to manage pain and symptoms. Therapy and interventions must be assessed and managed in terms of providing palliation and comfort without undue symptom burden for the hospice patient

or family.[2] In the December 16, 1983 Hospice final rule (48 FR 56010 through 56011), regarding what is related versus unrelated to the terminal illness, we stated: ''. . .we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case-by-case basis. It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients.'' Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis; all conditions are considered to be related to the terminal illness. It is also the responsibility of the hospice physician to document why a patient's medical needs will be unrelated to the terminal prognosis.

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

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

C. Services Covered by the Medicare Hospice Benefit

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

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before care is provided by, or under arrangements made by, that hospice program and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (described in section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available, as needed, to beneficiaries 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act). Upon the implementation of the hospice benefit, the Congress expected hospices to continue to use volunteer services, though these services are not reimbursed by Medicare (see Section 1861(dd)(2)(E) of the Act and (48 FR 38149)). As stated in the August 22, 1983 Hospice proposed rule, the hospice interdisciplinary group should be comprised of paid hospice employees as well as hospice volunteers (48 FR 38149). This expectation supports the hospice philosophy of holistic, comprehensive, compassionate, end-of-life care.

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

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

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

D. Medicare Payment for Hospice Care

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

1. Omnibus Budget Reconciliation Act of 1989

Section 6005(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) amended section 1814(i)(1)(C) of the Act and provided for the following two changes in the

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

methodology concerning updating the daily payment rates: (1) Effective January 1, 1990, the daily payment rates for RHC and other services included in hospice care were increased to equal 120 percent of the rates in effect on September 30, 1989; and (2) the daily payment rate for RHC and other services included in hospice care for fiscal years (FYs) beginning on or after October 1, 1990, were the payment rates in effect during the previous Federal fiscal year increased by the hospital market basket percentage increase.

2. Balanced Budget Act of 1997

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

3. FY 1998 Hospice Wage Index Final Rule

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

4. FY 2010 Hospice Wage Index Final Rule

Inpatient hospital pre-floor and pre-reclassified wage index values, as described in the August 8, 1997 Hospice Wage Index final rule, are subject to either a budget neutrality adjustment or application of the wage index floor. Wage index values of 0.8 or greater are adjusted by the (BNAF). Starting in FY 2010, a 7-year phase-out of the BNAF began (August 6, 2009 FY 2010 Hospice Wage Index final rule, (74 FR 39384)), with a 10 percent reduction in FY 2010, an additional 15 percent reduction for a total of 25 percent in FY 2011, an additional 15 percent reduction for a total 40 percent reduction in FY 2012, an additional 15 percent reduction for a total of 55 percent in FY 2013, and an additional 15 percent reduction for a total 70 percent reduction in FY 2014. The phase-out will continue with an additional 15 percent reduction for a total reduction of 85 percent in FY 2015, and an additional 15 percent reduction for complete elimination in FY 2016. We note that the BNAF is an adjustment which increases the hospice wage index value. Therefore, the BNAF reduction is a reduction in the amount of the BNAF increase applied to the hospice wage index value. It is not a reduction in the hospice wage index value or in the hospice payment rates.

5. The Affordable Care Act

Starting with FY 2013 (and in subsequent FYs), the market basket percentage update under the hospice payment system referenced in sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity, as specified in section 1886(b)(3)(B)(xi)(II) of the Act, as amended by section 3132(a) of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act (Pub. L. 111–152) (collectively referred to as the Affordable Care Act)). In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions as specified in section 1814(i)(1)(C)(v) of the Act).

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

Section 1814(a)(7)(D)(i) of the Act was amended by section 3132(b)(2)(D)(i) of the Affordable Care Act, and requires, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary's hospice care prior to the 180th-day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, we finalized in the CY 2011 Home Health Prospective Payment System final rule (75 FR 70435) that the 180th-day recertification and subsequent recertification's corresponded to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as amended by section 3132(a)(1)(B) of the Affordable Care Act, authorizes the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the Affordable Care Act would capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determines to be appropriate. The data collected may be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, we are required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

When the Medicare Hospice benefit was implemented, the Congress included an aggregate cap on hospice payments, which limits the total aggregate payments any individual hospice can receive in a year. The Congress stipulated that a ''cap amount'' be computed each year. The cap amount was set at $6,500 per beneficiary when first enacted in 1983 and is adjusted annually by the change in the medical

care expenditure category of the consumer price index for urban consumers from March 1984 to March of the cap year (section 1814(i)(2)(B) of the Act). The cap year is defined as the period from November 1st to October 31st. As we stated in the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314) for the 2012 cap year and subsequent cap years, the hospice aggregate cap will be calculated using the patient-by-patient proportional methodology, within certain limits. We will allow existing hospices the option of having their cap calculated via the original streamlined methodology, also within certain limits. New hospices will have their cap determinations calculated using the patient-by-patient proportional methodology. The patient-by-patient proportional methodology and the streamlined methodology are two different methodologies for counting beneficiaries when calculating the hospice aggregate cap. A detailed explanation of these methods is found in the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314). If a hospice's total Medicare reimbursement for the cap year exceeded the hospice aggregate cap, then the hospice must repay the excess back to Medicare.

7. FY 2015 Hospice Rate Update Final Rule

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

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

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

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

8. IMPACT Act of 2014

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

E. Trends in Medicare Hospice Utilization

Since the implementation of the hospice benefit in 1983, and especially within the last decade, there has been substantial growth in hospice utilization. The number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to over 1.3 million in FY 2013. Similarly, Medicare hospice expenditures have risen from $2.8 billion in FY 2000 to an estimated $15.3 billion in FY 2013. Our Office of the Actuary (OACT) projects that hospice expenditures are expected to continue to increase, by approximately 8 percent annually, reflecting an increase in the number of Medicare beneficiaries, more beneficiary awareness of the Medicare Hospice Benefit for end-of-life care, and a growing preference for care provided in home and community-based settings. However, this increased spending is partly due to an increased average lifetime length of stay for beneficiaries, from 54 days in 2000 to 98.5 days in FY 2013, an increase of 82 percent.

There have also been changes in the diagnosis patterns among Medicare hospice enrollees. Specifically, there were notable increases between 2002

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

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

Rank	ICD–9/Reported Principal Diagnosis	Count	Percentage
	Year: FY 2002		
1	162.9 Lung Cancer	73,769	11
2	428.0 Congestive Heart Failure	45,951	7
3	799.3 Debility Unspecified	36,999	6
4	496 COPD	35,197	5
5	331.0 Alzheimer's Disease	28,787	4
6	436 CVA/Stroke	26,897	4
7	185 Prostate Cancer	20,262	3
8	783.7 Adult Failure To Thrive	18,304	3
9	174.9 Breast Cancer	17,812	3
10	290.0 Senile Dementia, Uncomp	16,999	3
11	153.0 Colon Cancer	16,379	2
12	157.9 Pancreatic Cancer	15,427	2
13	294.8 Organic Brain Synd Nec	10,394	2
14	429.9 Heart Disease Unspecified	10,332	2
15	154.0 Rectosigmoid Colon Cancer	8,956	1
16	332.0 Parkinson's Disease	8,865	1
17	586 Renal Failure Unspecified	8,764	1
18	585 Chronic Renal Failure (End 2005)	8,599	1
19	183.0 Ovarian Cancer	7,432	1
20	188.9 Bladder Cancer	6,916	1
	Year: FY 2007		
1	799.3 Debility Unspecified	90,150	9
2	162.9 Lung Cancer	86,954	8
3	428.0 Congestive Heart Failure	77,836	7
4	496 COPD	60,815	6
5	783.7 Adult Failure To Thrive	58,303	6
6	331.0 Alzheimer's Disease	58,200	6
7	290.0 Senile Dementia Uncomp	37,667	4
8	436 CVA/Stroke	31,800	3
9	429.9 Heart Disease Unspecified	22,170	2
10	185 Prostate Cancer	22,086	2
11	174.9 Breast Cancer	20,378	2
12	157.9 Pancreas Unspecified	19,082	2
13	153.9 Colon Cancer	19,080	2
14	294.8 Organic Brain Syndrome NEC	17,697	2
15	332.0 Parkinson's Disease	16,524	2
16	294.10 Dementia In Other Diseases w/o Behav. Dist	15,777	2
17	586 Renal Failure Unspecified	12,188	1
18	585.6 End Stage Renal Disease	11,196	1
19	188.9 Bladder Cancer	8,806	1
20	183.0 Ovarian Cancer	8,434	1
	Year: FY 2013		
1	799.3 Debility Unspecified	127,415	9
2	428.0 Congestive Heart Failure	96,171	7
3	162.9 Lung Cancer	91,598	6
4	496 COPD	82,184	6
5	331.0 Alzheimer's Disease	79,626	6
6	783.7 Adult Failure To Thrive	71,122	5
7	290.0 Senile Dementia, Uncomp	60,579	4
8	429.9 Heart Disease Unspecified	36,914	3
9	436 CVA/Stroke	34,459	2
10	294.10 Dementia In Other Diseases w/o Behavioral Dist	30,963	2
11	332.0 Parkinson's Disease	25,396	2

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

Rank	ICD–9/Reported Principal Diagnosis	Count	Percentage
12	153.9 Colon Cancer	23,228	2
13	294.20 Dementia Unspecified w/o Behavioral Dist	23,224	2
14	174.9 Breast Cancer	23,059	2
15	157.9 Pancreatic Cancer	22,341	2
16	185 Prostate Cancer	21,769	2
17	585.6 End-Stage Renal Disease	19,309	1
18	518.81 Acute Respiratory Failure	15,965	1
19	294.8 Other Persistent Mental Dis.—classified elsewhere	14,372	1
20	294.11 Dementia In Other Diseases w/Behavioral Dist	13,687	1
	Year: FY 2014		
1	331.0 Alzheimer's disease	127,438	9
2	428.0 Congestive heart failure, unspecified	106,570	8
3	162.9 Lung Cancer	89,726	6
4	496 COPD	78,643	6
5	290.0 Senile dementia, uncomplicated	40,120	3
6	429.9 Heart disease, unspecified	36,929	3
7	436 CVA/Stroke	33,466	2
8	294.20 Dementia, unspecified, without behavioral disturbance	33,119	2
9	332.0 Parkinson's Disease	30,070	2
10	153.9 Colon Cancer	23,385	2
11	174.9 Breast Cancer	23,343	2
12	157.9 Pancreatic Cancer	22,521	2
13	185 Prostate Cancer	22,136	2
14	585.6 End stage renal disease	21,467	2
15	294.10 Dementia in conditions classified elsewhere w/o behav disturbance.	19,523	1
16	331.2 Senile degeneration of brain	18,660	1
17	518.81 Acute respiratory failure	17,347	1
18	290.40 Vascular dementia, uncomplicated	17,220	1
19	491.21 Obstructive chronic bronchitis with (acute) exacerbation	15,985	1
20	429.2 Cardiovascular disease, unspecified	14,186	1

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

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

III. Provisions of the Proposed Rule

A. Hospice Payment Reform Research and Analyses

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

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

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

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

potential research and analyses to consider for hospice payment reform.

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

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

1. Pre-Hospice Spending

In 1982, the Congress introduced hospice into the Medicare program as an alternative to aggressive treatment at the end of life. During the development of the benefit, multiple testimonies from industry leaders and hospice families, it was reported that hospices provided high-quality, compassionate and humane care while also offering a reduction in Medicare costs.[5] Additionally, a Congressional Budget Office (CBO) study asserted that hospice care would result in sizable savings over conventional hospital care.[6] Those savings estimates were based on a comparison of spending in the last 6 months of life for a cancer patient not utilizing hospice care versus the cost of hospice care for the 6 months preceding death.[7] The original language for section 1814(i) of the Act (prior to August 29, 1983) set the hospice aggregate cap amount at 40 percent of the average Medicare per capita expenditure amount for cancer patients in the last 6 months of life. When the hospice benefit was created, the average lifetime length of stay for a hospice patient was between 55 and 75 days. Since the implementation of the Medicare hospice benefit, the principal diagnosis for patients electing the hospice benefit has changed from primarily cancer diagnoses in 1983 to primarily non-cancer diagnoses in FY 2014.[8] Alzheimer's disease and Congestive Heart Failure (CHF) were the most reported principal diagnoses comprising 17 percent of all diagnoses reported (see Table 2 in section II.E) in FY 2014.

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

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

	Estimates of daily non-hospice Medicare spending prior to first hospice admission									Mean lifetime LOS
	180 day look-back			90 day look-back			30 day look-back			
	25th pct.	Median	75th pct.	25th pct.	Median	75th pct.	25th pct.	Median	75th pct.	
All Diagnoses	$47.04	$117.73	$240.73	$55.75	$157.89	$337.97	$57.66	$266.84	$545.44	73.8
Alzheimer's, Dementia, and Parkinson's	23.39	66.84	162.60	23.06	82.00	220.12	21.02	105.24	368.30	119.3
CVA/Stroke	56.18	116.86	239.30	82.32	170.40	352.74	150.21	352.41	622.23	47.4

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

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

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

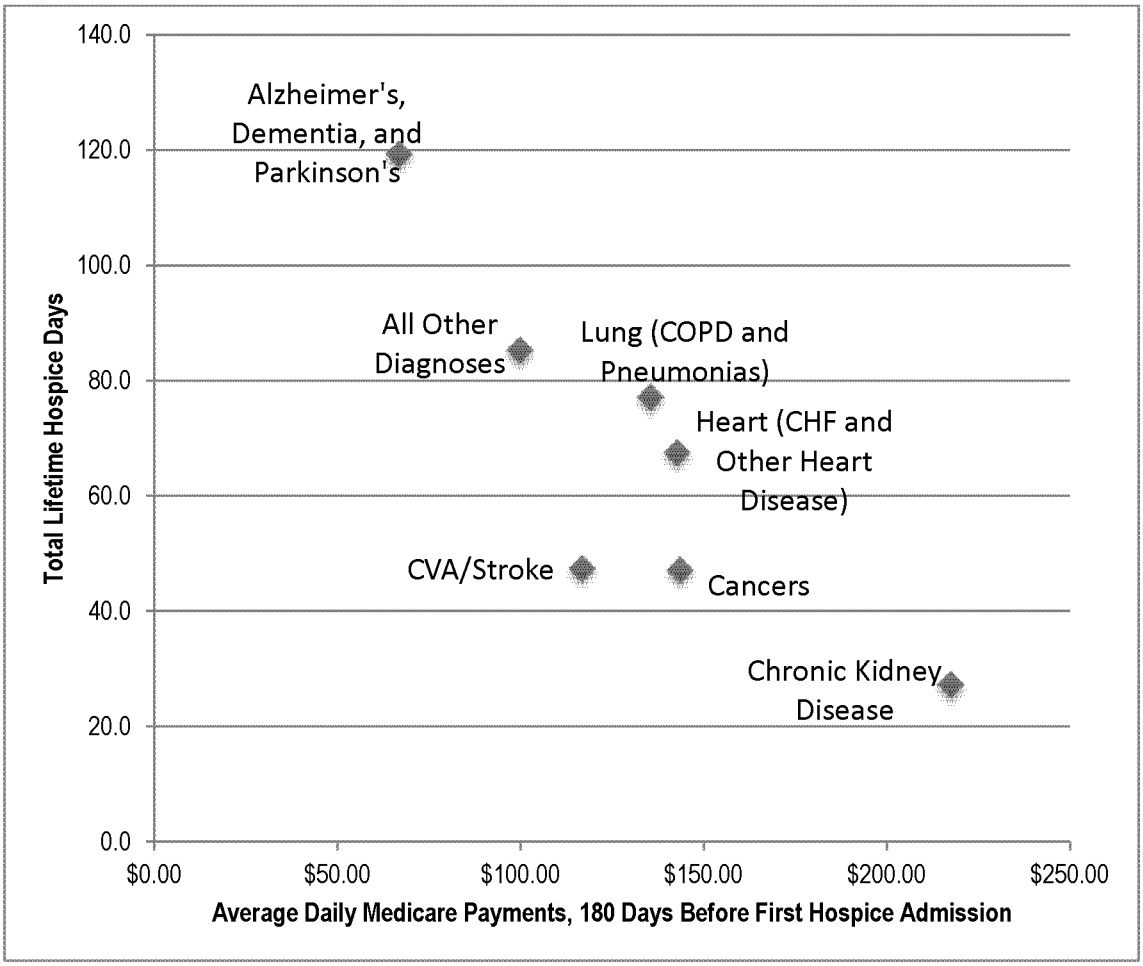
[8] Connor, S. (2007). Development of Hospice and Palliative Care in the Unites States. OMEGA. 56(1), 89–99. doi:102190/OM.5.1.h.

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

	Estimates of daily non-hospice Medicare spending prior to first hospice admission									Mean lifetime LOS
	180 day look-back			90 day look-back			30 day look-back			
	25th pct.	Median	75th pct.	25th pct.	Median	75th pct.	25th pct.	Median	75th pct.	
Cancers	62.81	143.56	265.58	78.30	188.08	360.92	81.52	289.85	569.67	47.1
Chronic Kidney Disease	94.78	217.46	402.10	126.41	293.18	541.41	199.01	466.25	820.78	27.3
Heart (CHF and Other Heart Disease)	61.28	135.48	255.53	80.62	186.52	364.24	101.80	325.15	588.50	77.2
Lung (COPD and Pneumonias)	65.53	142.78	272.13	90.68	201.02	401.12	126.51	367.68	685.17	67.5
All Other Diagnoses	36.00	99.80	222.25	39.45	132.88	316.15	38.96	213.84	504.57	85.3

Source: All Medicare Parts A, B, and D claims for FY 2013 from the Chronic Conditions Data Warehouse (CCW) retrieved March, 2015.
Note(s): Estimates drawn from FY2013 hospice decedents who were first-time hospice admissions, ages 66+ at hospice admission, admitted since 2006, and not enrolled in Medicare Advantage prior to admission. All payments are inflation-adjusted to September 2013 dollars using the Consumer Price Index (Medical Care; All Urban Consumers).

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



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

including those with Alzheimer's disease, other related dementias and Parkinson's disease. Typically, these conditions are associated with longer disease trajectories, progressive loss of functional and cognitive abilities, and more difficult prognostication. Research has shown that the majority of dementia patients are cared for at home, thereby causing informal costs that put an economic burden on families rather than on healthcare systems.[9] Additionally, research using the National Long-Term Care Survey (NLCS) merged with Medicare claims; researchers found that patients with Alzheimer's disease and related conditions do not have higher Medicare expenditures over the last 5 years of their life than the non-demented elderly.[10] Finally, research conducted by the RAND Corporation and published in the Annals of Internal Medicine in February of 2004 found that ''adjusted mean [Medicare] expenditures were 4.0 percent higher overall among hospice enrollees than among non-enrollees. Adjusted mean [Medicare] expenditures were 1 percent lower for hospice enrollees with cancer than for patients with cancer who did not use hospice. Savings were highest (7 percent to 17 percent) among enrollees with lung cancer and other very aggressive types of cancer diagnosed in the last year of life. [Medicare] Expenditures for hospice enrollees without cancer were 11 percent higher than for non-enrollees, ranging from 20 percent to 44 percent for patients with dementia and 0 percent to 16 percent for those with chronic heart failure or failure of most other organ systems''.[11] While analysis examining pre-hospice spending for hospice patients according to their diagnosis reported on the hospice claim has some limitations, it does show that, depending on the type of research study design selected, different conclusions can be drawn regarding the effect of Alzheimer's disease and dementia on medical care costs.[12]

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

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

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

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

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

When a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the terminal illness and related conditions, except for services provided by the designated hospice and the attending physician as described in section II.D.7. However, Medicare payment is allowed for covered Medicare items or services that are unrelated to the terminal illness and related conditions (that is, the terminal prognosis). When a hospice beneficiary receives items or services unrelated to the terminal illness and related conditions from a non-hospice provider, that provider can bill Medicare for the items or services, but must include on the claim a GW (service not related to the hospice patient's terminal condition) modifier (if billed on a professional claim),[13] or condition code 07 (if billed on an institutional claim).[14] Prescription Drug Events (PDEs) unrelated to the terminal prognosis for which hospice beneficiaries are receiving hospice care are billed to Part D and do not require a modifier or a condition code. We reported initial findings on CY 2012 non-hospice spending during a hospice election in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452). This section updates our analysis of non-hospice spending during a hospice election using FY 2013 data.

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

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

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

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

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

Non-hospice Medicare expenditures occurring during a hospice election in FY 2013 were $694.1 million for Parts A and B spending plus $347.1 million for Part D spending, or approximately $1 billion dollars total. This figure is comparable to the estimated $1 billion MedPAC reported during its December

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

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

2013 public meeting.[15] Associated with this $1 billion in Medicare spending were cost sharing liabilities such as co-payments and deductibles that beneficiaries incurred. Hospice beneficiaries had $132.5 million in cost-sharing for items and services that were billed to Medicare Parts A and B, and $50.9 million in cost-sharing for drugs that were billed to Medicare Part D, while they were in a hospice election. In total, this represents an FY 2013 beneficiary liability of $183.4 million for Parts A, B, and D items or services provided to hospice beneficiaries during a hospice election. Therefore, the total non-hospice costs paid by Medicare or beneficiaries for items or services provided to hospice beneficiaries during a hospice election were over $1.2 billion in FY 2013.

In a recent report, the HHS Office of Inspector General (OIG) identified instances where Medicare may be paying under Part D for drugs that should be provided by the hospice as part of the plan of care.[16] To assist CMS in identifying and evaluating instances where drugs, supplies, durable medical equipment (DME), and Part B services provided to hospice patients appear to be related to the principal diagnosis reported on the hospice claim, but were billed separately to other parts of the Medicare program, Acumen, LLC developed case studies that were reviewed and evaluated by CMS clinical staff.[17] Although hospice beneficiaries are allowed to continue receiving care outside the hospice benefit for conditions that are unrelated to the terminal illness and related conditions (that is, unrelated to the terminal prognosis), § 418.56(c) requires hospices to provide all services necessary for the palliation and management of the terminal illness and related conditions.

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

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

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

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

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) products whose use was initiated during a hospice stay are likely related to the terminal prognosis. Table 5 and 6 below summarizes total concurrent billing for DMEPOS products by Berenson-Eggers Types of Service (BETOS) categories and concurrent Durable Medical Equipment (DME) billing by the top 20 principal diagnoses as reported on hospice claims in CY 2013.[18] These diagnoses comprised 2.3 million hospice stays, and accounted for $27.1 million in total concurrent spending for DME products. This amount does not include spending for DME rental products that beneficiaries began using prior to a hospice stay.

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

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

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

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

We noted that hospice beneficiaries with hospice claims-reported principal diagnoses of chronic airway obstruction, congestive heart failure, cerebral degeneration and lung cancer were receiving services clinically indicated and recommended for these conditions outside of the hospice benefit, which is in violation of requirements regarding the Medicare hospice benefit. This could be attributed to hospices

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

incorrectly classifying conditions as unrelated and referring patients to non-hospice providers, not communicating and coordinating the care and services needed to manage the needs of the hospice beneficiary, or deliberately, to avoid costs. The case studies below are focused on four of the most commonly reported principal hospice diagnoses on hospice claims (see Table 2 in section II.E) based on evidence based clinical guidelines as described for each principal hospice diagnosis.

Malignant Neoplasm of the Trachea, Bronchus, and Lung

Malignant neoplasm of the trachea, bronchus, and lung (or lung cancer) is defined by ICD–9 diagnosis codes beginning with 162 and describes malignant cancers affecting various part of the pulmonary system. Symptoms for this class of conditions may include chronic and worsening cough, shortness of breath, chest pain, metastatic bone pain, and anorexia and weight loss. Clinical practice guidelines for end-stage cancer recommend treatment and management of refractory symptoms including pain, mucositis, dyspnea, fatigue, depression and anorexia through the use of pharmacological interventions including nonsteroidal anti-inflammatories, corticosteroids, opioids and antidepressants.[19] Additionally, evidence shows that palliative chemotherapy and radiotherapy can provide symptom relief from bone and brain metastasis.[20] Recommended interventions for dyspnea include treatment of the underlying reason such as, thoracentesis for pleural effusion, bronchodilators and systemic corticosteroids for inflammation and secretions, and supportive measures such supplemental oxygen, opioids and anxiolytics to decrease the sensation of breathlessness.[21]

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

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

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

Chronic Airway Obstruction

Chronic airway obstruction is defined by ICD–9 diagnosis codes beginning with 496 and includes chronic lung disease with unspecified cause, and is characterized by inflammation of the lungs and airways. Typical symptoms of these pulmonary diseases include increasing and disabling shortness of breath, labored breathing, increased coughing, increased heart rate, decreased functional reserve, increased infections and unintentional, progressive weight loss. Evidence-based practice supports the benefits of oral opioids, neuromuscular electrical stimulation, chest wall vibration, walking aids, respiratory assist devices and pursed-lip breathing in the management of dyspnea in the individual patient with advanced COPD.[22] Oxygen is recommended for COPD patients with resting hypoxemia for symptomatic benefit.[23] Additionally, clinical practice guidelines recommend inhaled bronchodilators, systemic corticosteroids, and pulmonary physiotherapy for the management of COPD exacerbations.[24] Analysis conducted by Acumen, LLC, shows concurrently billed Part D drugs included 130,283 stays for beneficiaries with ICD–9 code 469 listed as a primary diagnosis on the hospice claim. Additionally, concurrently billed Part B services included 198,098 such stays. Table 8 below summarizes concurrent payments for services that are potentially related to this class of conditions. In CY 2013, concurrent billing for all services related this terminal condition comprised $10.4 million. Part D drugs that should have been covered under the hospice benefit for the treatment of this condition accounted for $8.6 million. DME services that were billed during hospice stays related to this condition during the same time amounted to $1.2 million dollars.[25] Finally, concurrent services provided in Part B institutional settings accounted for $605,110.

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

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

[21] ibid.

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

[23] ibid

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

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

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

Type of service	Description	Total payment
Drugs/Part D	Common Palliative Drugs [26]	$1,757,326
Drugs/Part D	Antiasthmatics & Bronchodilators	6,545,089
Drugs/Part D	Corticosteroids	141,179
Drugs/Part D	Respiratory Agents	148,793
DME	Oxygen Equipment and Supplies [27]	525,276
DME	Hospital Beds	480,854
DME	Wheelchairs	196,692
Part B Institutional	Diagnostic Imaging	605,110
Total		10,400,319

Cerebral Degeneration

Cerebral degeneration is defined by ICD–9 diagnosis codes beginning with 331, and includes conditions such as Alzheimer's disease and Reye's syndrome. These conditions are typically characterized by a progressive loss of cognitive function with symptoms including the loss of memory and changes in language ability, behavior, and personality. Additionally, as these cerebral degenerations progress, other clinical manifestations occur such as dysphagia, motor dysfunction, impaired mobility, increased need for activities of daily living assistance, urinary and fecal incontinence, weight loss and muscle wasting. Individuals with these conditions are also at increased risk for aspiration, falls, pneumonias, decubitus ulcers and urinary tract infections. Clinical practice guidelines for the treatment of cerebral degenerative conditions includes pharmacological interventions including Angiotensin Converting Enzyme inhibitors, memantine or combination therapy depending on severity of disease, as well as antidepressants, antipsychotics, psychostimulants, mood stabilizers, benzodiazepines and neuroleptics, depending on behavioral manifestations. Non-pharmacological interventions recommended include mental, behavioral and cognitive therapy, speech language pathology to address swallowing issues, and other interventions to treat and manage manifestations including pressure ulcers, cachexia and infections.[28]

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

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

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

Congestive Heart Failure

Congestive heart failure (CHF) is defined by ICD–9 diagnosis codes beginning with 428. CHF is characterized by symptoms such as shortness of breath, edema, diminished endurance, angina, productive cough and fatigue. For the management of congestive heart failure, clinical practice guidelines recommend pharmacological interventions including beta blockers, angiotensin converting enzyme inhibitors, angiotensin receptor blockers, diuretics, anti-platelets, anti-coagulants and digoxin, depending on symptomology and response or nonresponse to other treatments.[29] Nonpharmacological interventions recommended include continuous positive airway pressure and

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

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

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

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

supplemental oxygen for those with coexisting pulmonary disease.[30]

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

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

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

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

3. Live Discharge Rates

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

Federal regulations only provide limited opportunity for a Medicare hospice provider to discharge a patient from its care. In accordance with § 418.26, discharge from hospice care is permissible when the patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause. Hospices may not automatically or routinely discharge the patient at its discretion, even if the care may be costly or inconvenient. As we indicated in the FY 2015 Hospice Wage Index and Payment Rate Update proposed and final rules, we understand that the rate of live discharges should not be zero, given the uncertainties of prognostication and the ability of patients and their families to revoke the hospice election at any time. On July 1, 2012, we began collecting discharge information on the claim to capture the reason for all types of discharges which includes, death, revocation, transfer to another hospice, moving out of the hospice's service area, discharge for cause, or due to the patient no longer being considered terminally ill (that is, no longer qualifying for hospice services). Based upon the additional discharge information, Abt Associates, our research contractor performed analysis on FY 2013 claims to identify those beneficiaries who were discharged alive. The details of this analysis will be reported in the 2015 technical report and will be made available on the Hospice Center Web page. In order to better understand the characteristics of hospices with high live discharge rates, we examined the aggregate cap status, skilled visit intensity; average lengths of stay; and non-hospice spending rates per beneficiary.

Between 2000 and 2013, the overall rate of live discharges increased from 13.2 percent in 2000 to 18.3 percent in 2013. Among hospices with 50 or more discharges (discharged alive or deceased), there is significant variation

[30] Lindenfeld J, Albert NM, Boehmer JP, Collins SP, Ezekowitz JA, Givertz MM, Klapholz M, Moser DK, Rogers JG, Starling RC, Stevenson WG, Tang WHW, Teerlink JR, Walsh MN. Executive Summary: HFSA 2010 Comprehensive Heart Failure Practice Guideline. J Card Fail 2010;16:475e539.

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

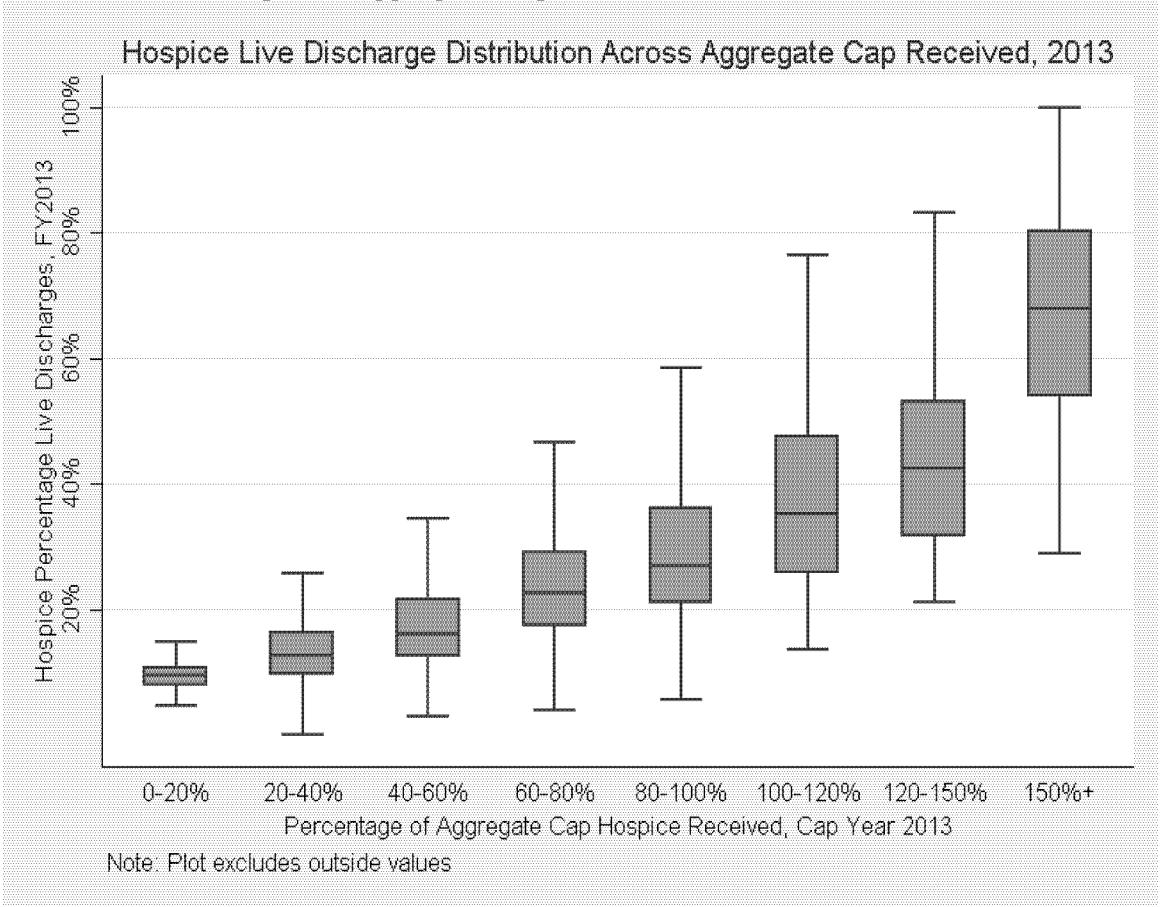
TABLE 11—DISTRIBUTION OF LIVE DISCHARGE RATES IN FY 2013 FOR HOSPICES WITH 50 OR MORE LIVE DISCHARGES

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

Note: n=3,096

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

Figure 2: Distribution of Hospice Live Discharge Rates by Hospice Payment Received Relative to the Hospice's Aggregate Cap Amount, FY 2013



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

live discharge rates at or above the 90th percentile provide, on average, 1.91 visits per week versus hospices with live discharge rates below the 90th percentile that provide, on average, 2.35 visits per week.

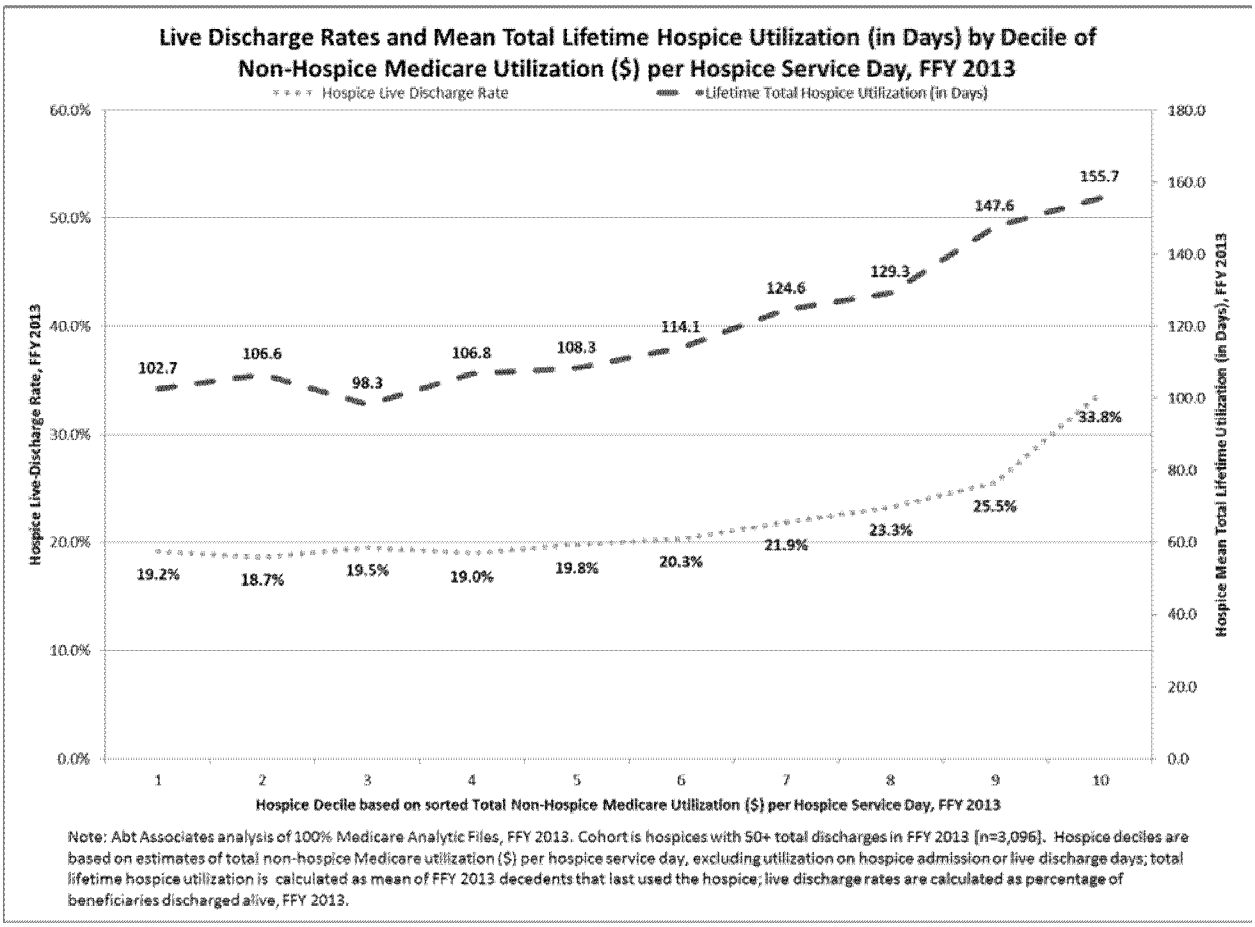
We examined whether there was a relationship between hospices with high live discharge rates, average lengths of stay, and non-hospice spending per beneficiary per day (see Table 12 and Figure 3 below). As described above in section III.A.2, we identified instances, in the aggregate and illustrated by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

Table 12: Mean Daily Non-Hospice Medicare Utilization and Sum Total Non-Hospice Utilization by Hospice Provider Decile based on sorted Non-Hospice Medicare Utilization per Hospice Day, FFY 2013

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

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

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



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

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

1. Statutory Authority and Background

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

This legislation emerged largely in response to MedPAC's March 2009 Report to Congress, which cited rapid growth of for-profit hospices and longer lengths of stay that raised concerns regarding a per diem payment structure that encouraged inappropriate utilization of the benefit.[31] MedPAC stated that a revised payment system would encourage hospice stays consistent with meeting the eligibility requirements of a medical prognosis of 6 months or less if the illness runs its normal course and increase greater provider accountability to monitor patients' conditions. In that same report, MedPAC stated that their goal was to ''strengthen the hospice payment system and not discourage enrollment in hospice, while deterring program abuse.''

As described in section III.A, CMS has transparently conducted payment reform activities and released research findings to the public since 2010. At that time, Abt Associates conducted a literature review and carried out original research to provide background on the current state of the Medicare

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

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

Over the past several years, MedPAC, the Government Accountability Office (GAO), and OIG, have all recommended that CMS collect more comprehensive data to better evaluate trends in utilization of the Medicare hospice benefit. Furthermore, section 3132(a)(1)(C) of the Affordable Care Act specifies that the Secretary may collect additional data and information on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate. We have received many suggestions for ways to improve data collection to support larger payment reform efforts in the future. Based on those suggestions and industry feedback, we began collecting additional information on the hospice claim form as of April 1, 2014.[32] Additionally, revisions to the cost report form for freestanding hospices became effective for cost reporting periods beginning on or after October 1, 2014. The instructions for completing the revised freestanding hospice cost report form are found in the Medicare Provider Reimbursement Manual-Part 2, chapter 43.[33] Once available, we expect the data from hospice claims and cost reports to provide more comprehensive information on the costs associated with the services provided by hospices to Medicare beneficiaries by level of care.

a. U-Shaped Payment Model

For over a decade, MedPAC and other organizations have reported findings that suggest that the hospice benefit's fixed per-diem payment system is inconsistent with the true variance of service costs over the course of an episode. Specifically, MedPAC cited both academic and non-academic studies, as well as its own analyses (as summarized and articulated in MedPAC's 2002,[34] 2004,[35] 2006,[36] 2008,[37] and 2009 [38] 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). According to MedPAC's 2008 Report to Congress, after the high costs at admission, the 'turning point' or 'break-even' point of profitability was found to be about 3 weeks (21 days).[39] Beyond 21 days, the magnitude of profitability deficits or 'marginal costs' declined and the lengths of stay became profitable—and more so—with longer stays.[40] Since hospice care is most profitable during the long, low-cost middle portions of an episode, longer episodes would potentially have very profitable, long middle segments. This financial incentive appears to have resulted in hospices enrolling beneficiaries that are not truly eligible for the benefit (that is, do not have a life expectancy of 6 months or less) and ''may lead some patients, families, and providers to implicitly regard hospice as a source of basic health care for failing patients who did not qualify for skilled nursing facility or home health care and did not qualify for Medicaid or otherwise could not afford other sources of long-term custodial care'',[41] rather than the end-of-life care for which the benefit was originally designed.

In its March 2009 report, ''Reforming Medicare's Hospice Benefit,'' MedPAC recommended that the Congress require CMS to implement a payment system that would adjust per-diem hospice rates based on the day's timing within the hospice episode, with the express goal of mitigating the apparent inconsistency between payments and resource utilization (that is, costs) in hospice episodes.[42] Specifically, MedPAC recommended that payments near the beginning and ending of a stay be set at higher levels (weighted upwards) and payments during the middle portion of care be set at lower levels (weighted downwards) to better mirror documented variation in cost over an episode's duration. Two primary weighting schemes were outlined in MedPAC's 2009 Report: A ''larger intensity adjustment'' (essentially a deeper U-shaped payment model, paying twice the base rate in the first 30/last 7 days and just a quarter of the daily rate in days 181+) and a ''smaller intensity adjustment'' (a relatively shallower U-shaped model, paying 1.5 times the base rate in the first 30/last 7 days and 0.375 times the daily rate in days 181+).

In its March 2015 Report to the Congress,[43] MedPAC reiterated its continued concerns regarding the ''mismatch between payments and hospice service intensity'' in the current hospice system and the ongoing need for payment reform. The Commission stated that ''Medicare's hospice payment system is not well aligned with the costs of providing care throughout a hospice episode. As a result, long hospice stays are generally more profitable than short stays.'' The Commission previously ''recommended that the hospice payment system be reformed to better match service intensity throughout a hospice episode of care (higher per diem payments at the beginning of the episode and at the end of the episode near the time of death and lower payments in the middle)''.

Other organizations have also explored the concept of a U-shaped payment model. The ASPE, in conjunction with its contractor, Acumen LLC, analyzed hospice enrollment and utilization data. ASPE's research

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

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

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

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

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

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

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

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

[40] Cheung, L., K. Fitch, and B. Pyenson. 2001. The costs of hospice care: An actuarial evaluation of the Medicare hospice benefit. Report by Milliman USA for the National Hospice and Palliative Care Organization, August 1. New York: Milliman USA.

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

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

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

demonstrated that the resource use curve becomes more pronounced as episode lengths increase for hospice users, indicating that this effect occurs because resource use declines more substantially for the middle days relative to beginning and ending days in longer episodes of hospice care than it does for shorter episodes. The decline in the center of the 'U' is deeper for those users who receive RHC only during their hospice episode, which is the case for the majority of hospice patients. Recently, CMS's contracting partner, Abt Associates, conducted analysis of FY 2013 hospice claims data, showing that of the approximately 92 million hospice days billed, 97.45 percent are categorized as RHC.

b. Tiered Payment Model

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

The groupings in the tiered payment model, presented in Table13 below, were developed through Abt Associates' analyses of resource utilization over the hospice episode and clinical input. Using a sample of 100 percent RHC hospice service days from 2011, Abt then developed payment weights for each grouping by calculating its relative resource utilization rate compared to the overall estimate of resource use across all RHC days (see Table 13 below).

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

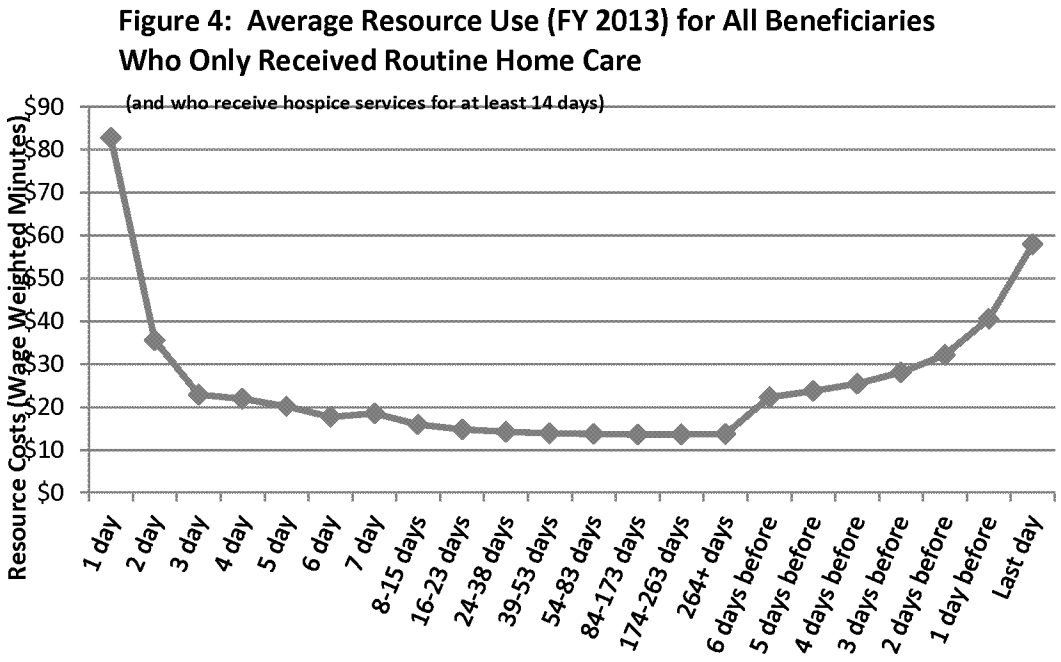
Group	Days of hospice	Implied weight
Group 1: RHC Days 1–5	2,800,144	2.3
Group 2: RHC Days 6–10	2,493,004	1.11
Group 3: RHC Days 11–30	7,767,918	0.97
Group 4: RHC Days 31+	65,958,740	0.86
Group 5: RHC During Last Seven Days, Skilled Visits During Last 2 Days	2,832,620	2.44
Group 6: RHC During Last Seven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

The payment weighting scheme in this system, derived from observed resource utilization across the entire episode, would produce higher payments during times when service is more intensive (the beginning of a stay or the end of life) and produce lower payments during times when service is less intensive (such as the ''middle period'' of the stay). The tiered payment model was discussed in more detail in the FY2014 Hospice Wage Index final rule (78 FR 48271) and in the Hospice Study Technical Report issued in April of 2013.[44]

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

Updated analysis of FY 2013 hospice claims data continues to demonstrate a U-Shaped pattern in of resource use. Increased utilization at both the beginning and end of a stay is demonstrated in Figure 4 below, where FY 2013 resource costs (as captured by wage-weighted minutes) are markedly higher in the first two days of a hospice election and once again in the six days preceding the date of death and on the date of death itself.

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



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

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

Visit length	First day (percent)	Second day (percent)	Third day (percent)	Fourth day (percent)	Fifth day (percent)	Sixth day (percent)	Seventh day (percent)	First through seventh day (percent)
No Visit	11.0	37.7	56.0	59.1	62.0	65.6	64.2	49.3
15mins to 1 hr	12.8	27.1	22.2	20.6	20.4	20.1	22.3	20.7
1hr15m to 2 hrs	32.0	21.4	14.3	13.4	12.2	10.4	10.2	16.9
2hrs15m to 3 hrs	22.8	8.6	4.8	4.5	3.6	2.5	2.2	7.5
3hrs15m to 3hrs45m	8.5	2.6	1.3	1.2	0.9	0.6	0.5	2.4
4 or more hrs	13.0	2.6	1.3	1.2	0.9	0.7	0.6	3.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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

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

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

Visit length (percent)	Day of death (percent)	One day before death (percent)	Two days before death (percent)	Three days before death (percent)	Four days before death (percent)	Five days before death (percent)	Six days before death (percent)	Last seven days combined (percent)
No Visit	27.8	38.7	45.2	49.8	53.2	55.8	58.0	46.3
15mins to 1 hr	23.9	27.9	26.5	25.1	24.2	23.5	22.8	24.9
1hr15m to 2 hrs	24.2	19.3	17.4	15.9	14.5	13.6	12.7	17.1
2hrs15m to 3 hrs	12.3	7.2	5.9	5.1	4.5	4.1	3.8	6.3
3hrs15m to 3hrs45m	4.4	2.4	1.9	1.6	1.4	1.2	1.1	2.1
4 or more hrs	7.4	4.3	3.0	2.4	2.1	1.9	1.6	3.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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

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

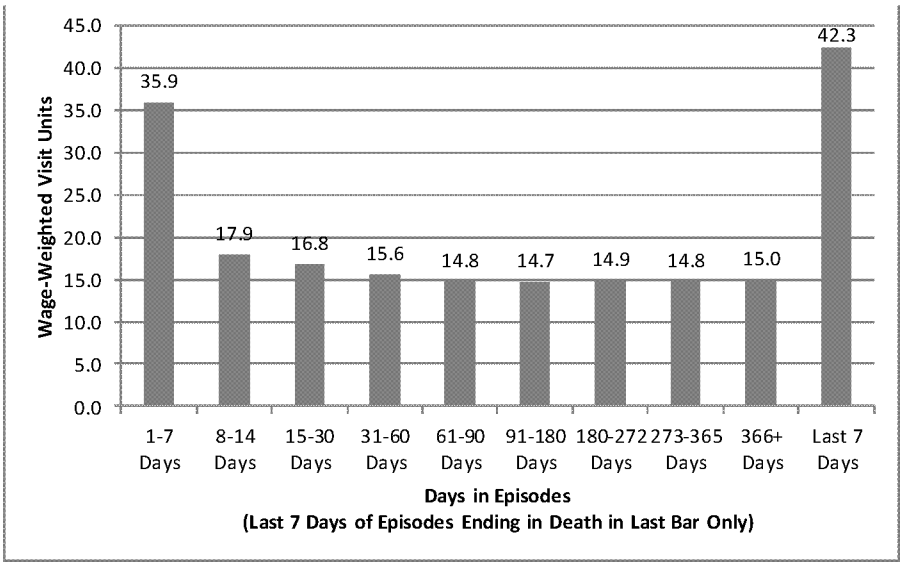
2. Proposed Routine Home Care Rates

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

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

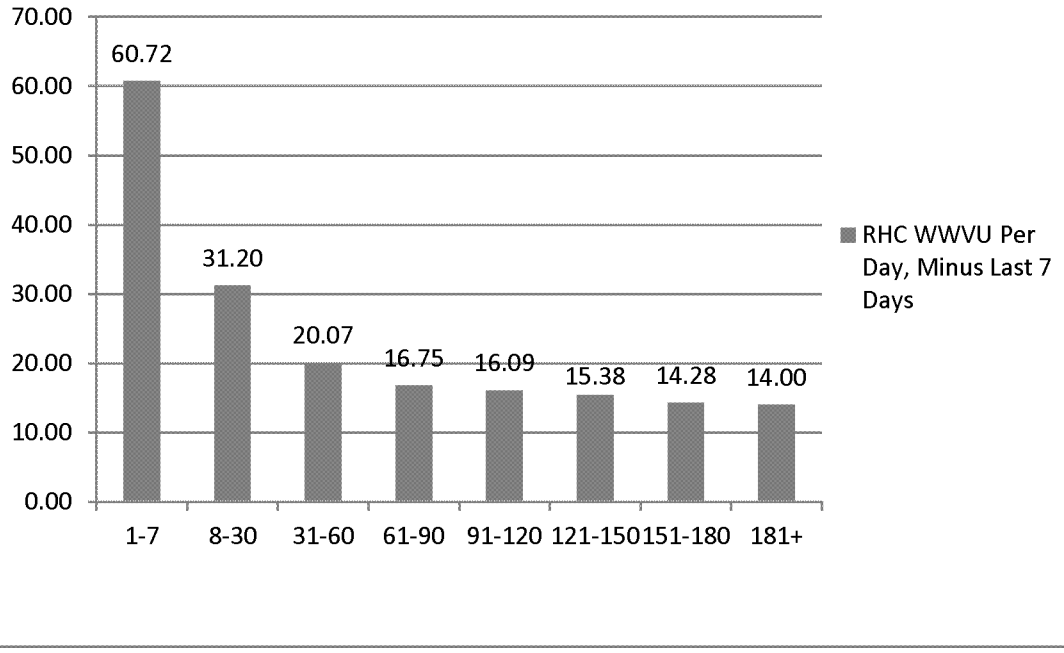
Figure 5 displays the pattern of wage-weighted minutes by time period within beneficiary episodes, but excluding the last 7 days of the episode for decedents. The wage-weighted minutes for the last 7 days are displayed separately by the bar furthest to the right of the Figure 5. The visit intensity curve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

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



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

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



The SIA payments based on actual visits provided would be added to the applicable rate during the last 7 days to reflect the rapid increase in visit intensity during that time period.

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

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

Phase of days in episode	Average wage-weighted minutes	RHC Days	Ratio of wage weighted minutes for each row divided by wage weighted minutes for days 1–7
1–7 Days	39.32	5,401,497	1.0000
8–14 Days	20.12	4,276,570	0.5118
15–30 Days	17.96	7,693,966	0.4567
31–60 Days	16.10	10,679,971	0.4095
61–90 Days	15.44	8,061,934	0.3927
91–180 Days	14.93	16,156,969	0.3797
181–272 Days	14.79	10,056,928	0.3762
273–365 Days	14.91	6,844,692	0.3791
365 up Days	15.05	15,962,038	0.3828
Total RHC Days	17.21	85,134,565	0.4377

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

To calculate the RHC payment rate for days 1 through 60, we compare the average wage-weighted minutes per day for days 1 through 60 to the overall average wage-weighted minutes per day multiplied by the labor portion of the FY 2015 RHC rate (column 4 in Table 17 below), which equals ($21.69/$17.21)*$109.48 = $137.98. Similarly, the RHC payment rate for days 61+ equals the average wage-weighted minutes per day for days 61+ divided by the overall average wage-weighted minutes per day multiplied by the labor portion of the FY 2015 RHC rate (column 4 in Table 17 below), which equals ($15.01/$17.21)*$109.48 = $95.48.

TABLE 17—FY 2015 RHC RATE REVISED LABOR PORTION CALCULATION

(1)	(2)	(3)	(4)	(5)	(6)
	FY 2015 RHC payment rate	RHC Labor-related share	FY 2015 RHC payment rate—labor portion	Average wage weighted minutes for RHC differential rate/ overall RHC average wage weighted minutes	Revised FY 2015 labor portion
Days 1–60	$159.34	× 0.6871	$109.48	× 1.2603 ($21.69/$17.21)	$137.98
Days 61+	159.34	× 0.6871	109.48	× 0.8722 ($15.01/$17.21)	95.48

As discussed in section III.C of this rule, currently, the labor-related share of the hospice payment rate for RHC is 68.71 percent. The non-labor share is equal to 100 percent minus the labor–related share, or 31.29 percent. Given the current base rate for RHC for FY 2015 of $159.34, the labor and non-labor components are as follows: for the labor-share portion, $159.34 multiplied by 68.71 percent equals $109.48; for the non-labor share portion, $159.34 multiplied by 31.29 percent equals $49.86. After determining the labor portion for the RHC rate for the first 60 days and the labor portion for the RHC rate for days 61 and over, we add the non-labor portion ($49.86) to the revised labor portions as described in column 6 in Table 17 above and in column 2 in Table 18 below. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the proposed RHC rates would need to be adjusted by a ratio of the total labor payments for RHC under using the current single rate for RHC to the estimated total labor payments for RHC using the two proposed rates for RHC. This ratio results in a budget neutrality adjustment of 0.9985 as shown in column 3 in Table 18 below. Finally, adding the revised labor portion with budget neutrality to the non-labor portion results in revised FY 2015 RHC payment rates of $187.63 for days 1 through 60 and $145.21 for days 61 and over.

TABLE 18—RHC BUDGET NEUTRALITY ADJUSTMENT FOR RHC RATES

(1)	(2)	(3)	(4)	(5)	(6)
	Revised FY 2015 labor portion	Budget neutrality factor [1]	Revised FY 2015 labor portion with budget neutrality	FY 2015 Non-labor portion	FY 2015 Revised RHC payment rates
Days 1–60	$137.98	× 0.9985	$137.77	$49.86	$187.63
Days 61+	95.49	× 0.9985	95.35	49.86	145.21

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

The proposed RHC rates for days 1 through 60 and days 61 and over (column 6 of Table 18 above) would replace the current single RHC per diem payment rate with two new RHC per diem rates for patients who require RHC level of care during a hospice election. In order to mitigate potential high rates of discharge and readmissions, we further propose that the count of days follow the patient. For hospice patients who are discharged and readmitted to hospice within 60 days of that discharge, his or her prior hospice days will continue to follow the patient and count toward his or her patient days for the receiving hospice upon hospice election. The hospice days would continue to follow the patient solely to determine whether the receiving hospice may bill at the 1 through 60 or 61+ RHC rate. The proposed policy does not preclude the receiving hospice (same or different hospice) from billing for a per diem payment for each hospice day. Therefore, we consider an ''episode'' of care to be a hospice election period or series of election periods separated by no more than a 60 day gap. We will monitor this proposal and trends in discharges and revocations for potential future refinements to address perverse incentives. This policy proposal attempts to better align RHC payment rates with resource use and is not intended to place an arbitrary limit on hospice services. 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 2015 Hospice Wage Index and Payment Rate Update final rule. Furthermore, program integrity and oversight efforts including but not limited to, medical review, MAC audits, Zone Program Integrity Contractor actions, Recovery Auditor activities, or suspension of provider billing privileges, are being considered to address fraud and abuse. We are soliciting public comment on all aspects of the proposed RHC payment rates as articulated in this section as well as this policy in conjunction with the proposed SIA payment described in section III.B.3 below.

3. Proposed Service Intensity Add-On (SIA) Payment

Section 1814(i)(1)(A) of the Act states that payment for hospice services must be equal to the costs which are reasonable and related to the cost of providing hospice care or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations. In addition, section 1814(i)(6)(D) of the Act, as amended by section 3132(a) of the Affordable Care Act, requires the Secretary to implement revisions to the methodology for determining the payment rates for RHCs and other services included in hospice care under Medicare Part A as the Secretary determines to be appropriate as described in section III.B.1 above. Given that independent analyses demonstrate a U-shaped cost pattern across hospice episodes, CMS believes that implementing revisions to the payment system that align with this concept supports the requirements of reasonable cost in section 1814(i)(A) of the Act. As articulated above, CMS considered implementing a tiered payment model as described in the FY 2014 Hospice Wage Index final rule (78 FR 48271) and in the Hospice Study Technical Report issued in April of 2013,[45] in order to better align payments with observed resource use over the length of a hospice stay. However, operational concerns and programmatic complexity led us to explore the concept of a SAI that could be implemented with minimal systems changes that limit reprocessing of hospice claims due to sequential billing requirements. In addition, while the tiered model represented a move toward better aligning payments with resource use, it only accounted for whether skilled services were provided in the last 2 days of life (Groups 5 and 6 in Table 13 above). Section III.B.1.c, above notes that on any given day during the first 7 days of a hospice election and last 7 days of life, only about 50 percent of the time are visits being made. In our view, increasing payments at the beginning of a hospice election and at the end of life for days where visits are not occurring does not align with the requirements of reasonable cost articulated in statute in section 1814(i)(A) of the Act. Therefore, as one of the first steps in addressing the observed misalignment between resource use and associated Medicare payments and in improving patient care through the promotion of skilled visits at end of life with minimal claims processing systems changes, CMS proposes to implement a SIA payment if the criteria outlined below are met

To qualify for the SIA payment, we propose that the following criteria must be met: (1) The day is billed as a RHC level of care day; (2) the day occurs during the last 7 days of life (and the beneficiary is discharged dead); (3) direct patient care is provided by a RN or a social worker (as defined by § 418.114(c) and § 418.114(b)(3), respectively) that day; and (4) the service is not provided in a skilled nursing facility/nursing facility (SNF/NF). The proposed SIA payment would be equal to the CHC) hourly payment rate (the current FY 2015 CHC rate is $38.75 per hour), multiplied by the amount of direct patient care provided by a RN or social worker for up to 4 hours total, per day, as long as the four criteria listed above are met. The proposed SIA payment would be paid in addition to the current per diem rate for the RHC level of care.

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

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

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

In 2011, the OIG published a report that focused specifically on Medicare payments to hospices who served a high percentage of nursing facility residents. The OIG found that from 2005 to 2009, the total Medicare spending for hospice care for nursing facility residents increased from $2.55 billion to $4.31 billion, an increase of almost 70 percent (OIG, 2011). When looking at hospices that had more than two-thirds of their beneficiaries in nursing facilities, the OIG found that 72 percent of these facilities were for-profit and received, on average, $3,182 more per beneficiary in Medicare payments than hospices overall. High-percentage hospices were found to serve beneficiaries who spent more days in hospice care, to the magnitude of 3 weeks longer than the average beneficiary. In addition, when looking at distributions in diagnoses, OIG found that high-percentage hospices enrolled beneficiaries who required less skilled care. In response to these findings, OIG recommended that CMS modify the current hospice reimbursement system to reduce the incentive for hospices to seek out beneficiaries in nursing facilities, who often receive longer but less complex and costly care.[46] Per the OIG recommendation, we are proposing to exclude SNF/NF sites of service from eligibility for the SIA payment.

The for-profit provider community has frequently highlighted its concerns regarding the lack of adequate reimbursement for hospice short stays in its public filings with the Securities and Exchange Commission (SEC) as described in MedPAC's 2008 Report to Congress.[47] Specifically, MedPAC cited records from the SEC for publicly traded for-profit hospice chains as evidence of a general acknowledgement of the nonlinear cost function of resource use within hospice episodes. For instance:

- VistaCare: ''Our profitability is largely dependent on our ability to manage costs of providing services and to maintain a patient base with a sufficiently long length of stay to attain profitability,'' and that ''cost pressures resulting from shorter patient lengths of stay . . . could negatively impact our profitability.'' [48]
- Odyssey HealthCare: ''Length of stay impacts our direct hospice care expenses as a percentage of net patient service revenue because, if lengths of stay decline, direct hospice care expenses, which are often highest during the earliest and latter days of care for a patient, are spread against fewer days of care.'' [49]

Short lengths of stay were also cited as a source of financial difficulties for small rural hospices (implying that longer stays were more profitable).[50] In the FY 2014 Hospice Wage Index and Payment Rate Update proposed rule, we stated that ''analysis conducted by Abt Associates found that very short hospice stays have a flatter curve than the U-shaped curve seen for longer stays, and that average hospice costs are much higher. These short stays are less U-shaped because there is not a lower-cost middle period between the time of admission and the time of death.'' The FY 2014 Hospice Wage Index and Payment Rate Update proposed rule went on to note that a ''short stay add-on'' was under consideration as a possible reform option (78 FR 27843). Public comments received in response to the proposed rule were favorable regarding a possible short stay add-on payment. Since the proposed SIA payment would be applicable to any 7-day period of time ending in the patient's death, hospice elections with short lengths of stay would receive an additional payment that would help mitigate the marginally higher costs associated with short lengths of stay, consistent with the 'reasonable cost' structure of the hospice payment system. For FY 2013, 32 percent of hospice stays were 7 days or less with 60 percent of stays lasting 30 days or less. The median length of stay in FY 2013 was 17 days.

Although Figure 4 above demonstrates that there is increased resource use during the first 2 days of an election, we are not proposing an additional SIA payment for the first or second day of a hospice election when the length of stay is beyond 7 days. According to MedPAC, the breakeven point for a hospice election is about three weeks after admission.[51] The proposed SIA payment for the last 7 days of life would provide additional reimbursement to help to mitigate the higher costs for stays lasting 3 weeks or less where spreading out the initial costs in the first 2 days of the election over a smaller number of days is not enough to make the overall stay profitable. Once a hospice stay reaches 3 weeks or more, the initial costs associated with the first 2 days of a hospice election can be spread out over a larger number of days, making the overall stay profitable. A stay of 7 days or less before death would be eligible for SIA payment on all days.

We believe that the proposed SIA payment helps to address MedPAC and industry concerns regarding the visit intensity at end of life and the concerns associated with the profitability of hospice short stays. The proposed RHC rates described in section III.B2 and SIA payment would advance hospice payment reform incrementally, as mandated by the Affordable Care Act while simultaneously maintaining flexibility for future refinements. Since this approach would be implemented within the current constructs of the hospice payment system, no major overhaul of the claims processing system or related claims/cost report forms would be required, minimizing burden for hospices as well as for Medicare. CMS needs to further assess whether the four levels of care and the current payment amounts, as well as the amounts after implementation of the SIA, will align with the actual cost of

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

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

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

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

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

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

providing hospice services. The hospice cost report was redesigned, effective for cost reporting periods beginning on October 1, 2014, and additional data are now being collected on the hospice claim form, effective April 1, 2014. Once additional data is available, CMS will continue to assess additional refinements that may inform more extensive policy and payment approaches, in accordance with the payment methodology reform required by the Affordable Care Act.

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

We also propose to continue to make the SIA payments budget neutral through an annual determination of the SBNF, which will then be applied to the RHC payment rate. The SBNF for the SIA payments would be calculated for each FY using the most current and complete fiscal year utilization data available at the time of rulemaking. Finally, we are soliciting public comment on all aspects of the proposed SIA payment as articulated in this section as well as the corresponding proposed changes to the regulations at § 418.302 in section VI. We are also proposing to change the word ''Intermediary'' to ''Medicare Administrative Contractor'' in the regulations text at § 418.302 and proposing technical regulations text changes to § 418.306 as described in section VI. As more data become available, CMS will continue to analyze hospice payments, costs, and utilization and will consider refining the SIA payment criteria if needed.

C. Proposed FY 2016 Hospice Wage Index and Rate Update

1. Proposed FY 2016 Hospice Wage Index

a. Background

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

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

In the FY 2006 Hospice Wage Index final rule (70 FR 45130), we adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003). This bulletin announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas. The bulletin is available online at *http://www.whitehouse.gov/omb/bulletins/b03-04.html.* In adopting the CBSA geographic designations for FY 2006, we provided for a 1-year transition with a blended wage index for all providers. For FY 2006, the wage index for each geographic area consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index. As discussed in the Hospice Wage Index final rule for FY 2006 (70 FR 45138), since the expiration of this 1-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

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

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

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

This proposed rule would update the hospice wage index values for FY 2016 using the FY 2015 pre-floor, pre-reclassified hospital wage index. As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values were then subject to either a budget neutrality adjustment or application of the hospice floor to compute the hospice wage index used to determine payments to hospices. Pre-floor, pre-reclassified hospital wage index values below 0.8 were adjusted by either: (1) The hospice BNAF; or (2) the hospice floor—a 15 percent increase subject to a maximum wage index value of 0.8; whichever results in the greater value.

The FY 2010 Hospice Wage Index rule finalized a provision to phase-out the BNAF over 7 years, with a 10 percent reduction in the BNAF in FY 2010, and an additional 15 percent reduction in each of the next 6 years, with complete phase out in FY 2016 (74 FR 39384). The 10 percent reduced BNAF for FY

2010 was 0.055598, based on a full BNAF of 0.061775; the additional 15 percent reduced BNAF for FY 2011 (for a cumulative reduction of 25 percent) was 0.045422, based on a full BNAF of 0.060562; the additional 15 percent reduced BNAF for FY 2012 (for a cumulative reduction of 40 percent) was 0.035156, based on a full BNAF of 0.058593; the additional 15 percent reduced BNAF for FY 2013 (for a cumulative reduction of 55 percent) was 0.027197, based on a full BNAF of 0.060438; the additional 15 percent BNAF for FY 2014 (for a cumulative reduction of 70 percent) was 0.018461, based on a full BNAF of 0.061538 and the additional 15 percent reduced BNAF for FY 2015 (for a cumulative reduction of 85 percent) is 0.009313, based on a full BNAF of 0.062804. For FY 2016, the BNAF is reduced by an additional and final 15 percent for a cumulative reduction of 100 percent. Therefore, for FY 2016, the BNAF is completely phased-out and eliminated.

Hospital wage index values which are less than 0.8 are still subject to the hospice floor calculation. The hospice floor equates to a 15 percent increase, subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15 which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

c. Proposed Implementation of New Labor Market Delineations

OMB has published subsequent bulletins regarding CBSA changes. On February 28, 2013, OMB issued OMB Bulletin No. 13–01, announcing revisions to the delineation of MSAs, Micropolitan Statistical Areas, and Combines Statistical Areas, and guidance on uses of the delineation in these areas. A copy of this bulletin is available online at: *http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf*. This bulletin states that it ''provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246–37252) and Census Bureau data.'' In the FY 2015 Hospice Wage Index final rule (79 FR 50483), we stated that if CMS incorporates OMB's new area delineations, based on the 2010 Census, in the FY 2015 hospital wage index, those changes would also be reflected in the FY 2016 hospice wage index. In the FY 2015 Inpatient Prospective Payment System (IPPS) final rule (79 FR 49951), we finalized the proposal to use OMB's new area delineations, based on the 2010 Census, in the FY 2015 hospital wage index. In addition, the new area delineations have been incorporated into the FY 2015 SNF PPS (79 FR 45628) and the CY 2015 Home Health (HH) PPS (79 FR 66032) using a 1-year transition with a blended wage index.

While the revisions OMB published on February 28, 2013, are not as sweeping as the changes made when we adopted the CBSA geographic designations for FY 2006, the February 28, 2013 bulletin does contain a number of significant changes. For example, there are new CBSAs, urban counties that have become rural, rural counties that have become urban, and existing CBSAs that have been split apart. We believe it is important for the hospice wage index to use the latest OMB delineations available in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. While CMS and other stakeholders have explored potential alternatives to the current CBSA-based labor market system (we refer readers to the CMS Web site at: *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html*), no consensus has been achieved regarding how best to implement a replacement system. As discussed in the FY 2005 IPPS final rule (69 FR 49027), ''While we recognize that MSAs are not designed specifically to define labor market areas, we believe they do represent a useful proxy for this purpose.'' We further believe that using the most current OMB delineations would increase the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels. We have reviewed our findings and impacts relating to the new OMB delineations, and have concluded that there is no compelling reason to further delay implementation. We are proposing to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13–01 for the hospice wage index effective beginning in FY 2016.

i. Micropolitan Statistical Areas

As discussed in the FY 2006 Hospice Wage Index proposed rule (70 FR 22397) and final rule (70 FR 45132), CMS considered how to use the Micropolitan Statistical Area definitions in the calculation of the wage index. OMB defines a ''Micropolitan Statistical Area'' as a CBSA ''associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000 (75 FR 37252). We refer to these as Micropolitan Areas. After extensive impact analysis, consistent with the treatment of these areas under the IPPS as discussed in the FY 2005 IPPS final rule (69 FR 49029 through 49032), CMS determined the best course of action would be to treat Micropolitan Areas as ''rural'' and include them in the calculation of each state's Hospice rural wage index (see 70 FR 22397 and 70 FR 45132). Thus, the hospice statewide rural wage index is determined using IPPS hospital data from hospitals located in non-MSA areas.

Based upon the 2010 Decennial Census data, a number of urban counties have switched status and have joined or became Micropolitan Areas, and some counties that once were part of a Micropolitan Area, have become urban. Overall, there are fewer Micropolitan Areas (541) under the new OMB delineations based on the 2010 Census than existed under the latest data from the 2000 Census (581). We believe that the best course of action would be to continue the policy established in the FY 2006 Hospice Wage Index final rule and include Micropolitan Areas in each state's rural wage index. These areas continue to be defined as having relatively small urban cores (populations of 10,000 to 49,999). Therefore, in conjunction with our proposal to implement the new OMB labor market delineations beginning in FY 2016 and consistent with the treatment of Micropolitan Areas under the IPPS, we are proposing to continue to treat Micropolitan Areas as ''rural'' and to include Micropolitan Areas in the calculation of each state's rural wage index.

ii. Urban Counties Becoming Rural

If we adopt the new OMB delineations (based upon the 2010 decennial Census data), a total of 37 counties (and county equivalents) that are currently considered urban would be considered rural beginning in FY 2016. Table 19 below lists the 37 counties that would change to rural status if we finalize our proposal to implement the new OMB delineations.

TABLE 19—COUNTIES THAT WOULD CHANGE TO RURAL STATUS

County	State	CBSA number from FY 2015 hospice wage index	CBSA name
Greene County	IN	14020	Bloomington, IN.
Anson County	NC	16740	Charlotte-Gastonia-Rock Hill, NC-SC.
Franklin County	IN	17140	Cincinnati-Middletown, OH-KY-IN.
Stewart County	TN	17300	Clarksville, TN-KY.
Howard County	MO	17860	Columbia, MO.
Delta County	TX	19124	Dallas-Fort Worth-Arlington, TX.
Pittsylvania County	VA	19260	Danville, VA.
Danville City	VA	19260	Danville, VA.
Preble County	OH	19380	Dayton, OH.
Gibson County	IN	21780	Evansville, IN-KY.
Webster County	KY	21780	Evansville, IN-KY.
Franklin County	AR	22900	Fort Smith, AR-OK.
Ionia County	MI	24340	Grand Rapids-Wyoming, MI.
Newaygo County	MI	24340	Grand Rapids-Wyoming, MI.
Greene County	NC	24780	Greenville, NC.
Stone County	MS	25060	Gulfport-Biloxi, MS.
Morgan County	WV	25180	Hagerstown-Martinsburg, MD-WV.
San Jacinto County	TX	26420	Houston-Sugar Land-Baytown, TX.
Franklin County	KS	28140	Kansas City, MO-KS.
Tipton County	IN	29020	Kokomo, IN.
Nelson County	KY	31140	Louisville/Jefferson County, KY-IN.
Geary County	KS	31740	Manhattan, KS.
Washington County	OH	37620	Parkersburg-Marietta-Vienna, WV-OH.
Pleasants County	WV	37620	Parkersburg-Marietta-Vienna, WV-OH.
George County	MS	37700	Pascagoula, MS.
Power County	ID	38540	Pocatello, ID.
Cumberland County	VA	40060	Richmond, VA.
King and Queen County	VA	40060	Richmond, VA.
Louisa County	VA	40060	Richmond, VA.
Washington County	MO	41180	St. Louis, MO-IL.
Summit County	UT	41620	Salt Lake City, UT.
Erie County	OH	41780	Sandusky, OH.
Franklin County	MA	44140	Springfield, MA.
Ottawa County	OH	45780	Toledo, OH.
Greene County	AL	46220	Tuscaloosa, AL.
Calhoun County	TX	47020	Victoria, TX.
Surry County	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC.

iii. Rural Counties Becoming Urban

If we finalize our proposal to implement the new OMB delineations (based upon the 2010 decennial Census data), a total of 105 counties (and county equivalents) that are currently designated rural would be considered urban beginning in FY 2016. Table 20 below lists the 105 counties that would change to urban status.

TABLE 20—COUNTIES THAT WOULD CHANGE TO URBAN STATUS

County	State	CBSA number	CBSA name
Utuado Municipio	PR	10380	Aguadilla-Isabela, PR.
Linn County	OR	10540	Albany, OR.
Oldham County	TX	11100	Amarillo, TX.
Morgan County	GA	12060	Atlanta-Sandy Springs-Roswell, GA.
Lincoln County	GA	12260	Augusta-Richmond County, GA-SC.
Newton County	TX	13140	Beaumont-Port Arthur, TX.
Fayette County	WV	13220	Beckley, WV.
Raleigh County	WV	13220	Beckley, WV.
Golden Valley County	MT	13740	Billings, MT.
Oliver County	ND	13900	Bismarck, ND.
Sioux County	ND	13900	Bismarck, ND.
Floyd County	VI	13980	Blacksburg-Christiansburg-Radford, VA.
De Witt County	IL	14010	Bloomington, IL.
Columbia County	PA	14100	Bloomsburg-Berwick, PA.
Montour County	PA	14100	Bloomsburg-Berwick, PA.
Allen County	KY	14540	Bowling Green, KY.
Butler County	KY	14540	Bowling Green, KY.
St. Mary's County	MD	15680	California-Lexington Park, MD.
Jackson County	IL	16060	Carbondale-Marion, IL.
Williamson County	IL	16060	Carbondale-Marion, IL.

TABLE 20—COUNTIES THAT WOULD CHANGE TO URBAN STATUS—Continued

County	State	CBSA number	CBSA name
Franklin County	PA	16540	Chambersburg-Waynesboro, PA.
Iredell County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Lincoln County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Rowan County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Chester County	SC	16740	Charlotte-Concord-Gastonia, NC-SC.
Lancaster County	SC	16740	Charlotte-Concord-Gastonia, NC-SC.
Buckingham County	VA	16820	Charlottesville, VA.
Union County	IN	17140	Cincinnati, OH-KY-IN.
Hocking County	OH	18140	Columbus, OH.
Perry County	OH	18140	Columbus, OH.
Walton County	FL	18880	Crestview-Fort Walton Beach-Destin, FL.
Hood County	TX	23104	Dallas-Fort Worth-Arlington, TX.
Somervell County	TX	23104	Dallas-Fort Worth-Arlington, TX.
Baldwin County	AL	19300	Daphne-Fairhope-Foley, AL.
Monroe County	PA	20700	East Stroudsburg, PA.
Hudspeth County	TX	21340	El Paso, TX.
Adams County	PA	23900	Gettysburg, PA.
Hall County	NE	24260	Grand Island, NE.
Hamilton County	NE	24260	Grand Island, NE.
Howard County	NE	24260	Grand Island, NE.
Merrick County	NE	24260	Grand Island, NE.
Montcalm County	MI	24340	Grand Rapids-Wyoming, MI.
Josephine County	OR	24420	Grants Pass, OR.
Tangipahoa Parish	LA	25220	Hammond, LA.
Beaufort County	SC	25940	Hilton Head Island-Bluffton-Beaufort, SC.
Jasper County	SC	25940	Hilton Head Island-Bluffton-Beaufort, SC.
Citrus County	FL	26140	Homosassa Springs, FL.
Butte County	ID	26820	Idaho Falls, ID.
Yazoo County	MS	27140	Jackson, MS.
Crockett County	TN	27180	Jackson, TN.
Kalawao County	HI	27980	Kahului-Wailuku-Lahaina, HI.
Maui County	HI	27980	Kahului-Wailuku-Lahaina, HI.
Campbell County	TN	28940	Knoxville, TN.
Morgan County	TN	28940	Knoxville, TN.
Roane County	TN	28940	Knoxville, TN.
Acadia Parish	LA	29180	Lafayette, LA.
Iberia Parish	LA	29180	Lafayette, LA.
Vermilion Parish	LA	29180	Lafayette, LA.
Cotton County	OK	30020	Lawton, OK.
Scott County	IN	31140	Louisville/Jefferson County, KY-IN.
Lynn County	TX	31180	Lubbock, TX.
Green County	WI	31540	Madison, WI.
Benton County	MS	32820	Memphis, TN-MS-AR.
Midland County	MI	33220	Midland, MI.
Martin County	TX	33260	Midland, TX.
Le Sueur County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Mille Lacs County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Sibley County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Maury County	TN	34980	Nashville-Davidson-Murfreesboro-Franklin, TN.
Craven County	NC	35100	New Bern, NC.
Jones County	NC	35100	New Bern, NC.
Pamlico County	NC	35100	New Bern, NC.
St. James Parish	LA	35380	New Orleans-Metairie, LA.
Box Elder County	UT	36260	Ogden-Clearfield, UT.
Gulf County	FL	37460	Panama City, FL.
Custer County	SD	39660	Rapid City, SD.
Fillmore County	MN	40340	Rochester, MN.
Yates County	NY	40380	Rochester, NY.
Sussex County	DE	41540	Salisbury, MD-DE.
Worcester County	MA	41540	Salisbury, MD-DE.
Highlands County	FL	42700	Sebring, FL.
Webster Parish	LA	43340	Shreveport-Bossier City, LA.
Cochise County	AZ	43420	Sierra Vista-Douglas, AZ.
Plymouth County	IA	43580	Sioux City, IA-NE-SD.
Union County	SC	43900	Spartanburg, SC.
Pend Oreille County	WA	44060	Spokane-Spokane Valley, WA.
Stevens County	WA	44060	Spokane-Spokane Valley, WA.
Augusta County	VA	44420	Staunton-Waynesboro, VA.
Staunton City	VA	44420	Staunton-Waynesboro, VA.
Waynesboro City	VA	44420	Staunton-Waynesboro, VA.
Little River County	AR	45500	Texarkana, TX-AR.
Sumter County	FL	45540	The Villages, FL.

TABLE 20—COUNTIES THAT WOULD CHANGE TO URBAN STATUS—Continued

County	State	CBSA number	CBSA name
Pickens County	AL	46220	Tuscaloosa, AL.
Gates County	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC.
Falls County	TX	47380	Waco, TX.
Columbia County	WA	47460	Walla Walla, WA.
Walla Walla County	WA	47460	Walla Walla, WA.
Peach County	GA	47580	Warner Robins, GA.
Pulaski County	GA	47580	Warner Robins, GA.
Culpeper County	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
Rappahannock County	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
Jefferson County	NY	48060	Watertown-Fort Drum, NY.
Kingman County	KS	48620	Wichita, KS.
Davidson County	NC	49180	Winston-Salem, NC.
Windham County	CT	49340	Worcester, MA-CT.

iv. Urban Counties Moving to a Different Urban CBSA

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to another urban CBSA under our proposal to adopt the new OMB delineations. In other cases, applying the new OMB delineations would involve a change only in CBSA name or number, while the CBSA continues to encompass the same constituent counties. For example, CBSA 29140 (Lafayette, IN), would experience both a change to its number and its name, and would become CBSA 29200 (Lafayette-West Lafayette, IN), while all of its three constituent counties would remain the same. We are not discussing these proposed changes in this section because they are inconsequential changes with respect to the hospice wage index. However, in other cases, if we adopt the new OMB delineations, counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. In one type of change, an entire CBSA would be subsumed by another CBSA. For example, CBSA 37380 (Palm Coast, FL) currently is a single county (Flagler, FL) CBSA. Flagler County would be a part of CBSA 19660 (Deltona-Daytona Beach-Ormond Beach, FL) under the new OMB delineations. In another type of change, some CBSAs have counties that would split off to become part of or to form entirely new labor market areas. For example, CBSA 37964 (Philadelphia Metropolitan Division of MSA 37980) currently is comprised of 5 Pennsylvania counties (Bucks, Chester, Delaware, Montgomery, and Philadelphia). If we adopt the new OMB delineations, Montgomery, Bucks, and Chester counties would split off and form the new CBSA 33874 (Montgomery County-Bucks County-Chester County, PA Metropolitan Division of MSA 37980), while Delaware and Philadelphia counties would remain in CBSA 37964. Finally, in some cases, a CBSA would lose counties to another existing CBSA if we adopt the new OMB delineations. For example, Lincoln County and Putnam County, WV would move from CBSA 16620 (Charleston, WV) to CBSA 26580 (Huntington-Ashland, WV KY OH). CBSA 16620 would still exist in the new labor market delineations with fewer constituent counties. Table 21 lists the urban counties that would move from one urban CBSA to another urban CBSA if we adopt the new OMB delineations.

TABLE 21—COUNTIES THAT WOULD CHANGE TO A DIFFERENT CBSA

Previous CBSA	New CBSA	County	State
11300	26900	Madison County	IN.
11340	24860	Anderson County	SC.
14060	14010	McLean County	IL.
37764	15764	Essex County	MA.
16620	26580	Lincoln County	WV.
16620	26580	Putnam County	WV.
16974	20994	DeKalb County	IL.
16974	20994	Kane County	IL.
21940	41980	Ceiba Municipio	PR.
21940	41980	Fajardo Municipio	PR.
21940	41980	Luquillo Municipio	PR.
26100	24340	Ottawa County	MI.
31140	21060	Meade County	KY.
34100	28940	Grainger County	TN.
35644	35614	Bergen County	NJ.
35644	35614	Hudson County	NJ.
20764	35614	Middlesex County	NJ.
20764	35614	Monmouth County	NJ.
20764	35614	Ocean County	NJ.
35644	35614	Passaic County	NJ.
20764	35084	Somerset County	NJ.
35644	35614	Bronx County	NY.
35644	35614	Kings County	NY.
35644	35614	New York County	NY.
35644	20524	Putnam County	NY.
35644	35614	Queens County	NY.
35644	35614	Richmond County	NY.

TABLE 21—COUNTIES THAT WOULD CHANGE TO A DIFFERENT CBSA—Continued

Previous CBSA	New CBSA	County	State
35644	35614	Rockland County	NY.
35644	35614	Westchester County	NY.
37380	19660	Flagler County	FL.
37700	25060	Jackson County	MS.
37964	33874	Bucks County	PA.
37964	33874	Chester County	PA.
37964	33874	Montgomery County	PA.
39100	20524	Dutchess County	NY.
39100	35614	Orange County	NY.
41884	42034	Marin County	CA.
41980	11640	Arecibo Municipio	PR.
41980	11640	Camuy Municipio	PR.
41980	11640	Hatillo Municipio	PR.
41980	11640	Quebradillas Municipio	PR.
48900	34820	Brunswick County	NC.
49500	38660	Guánica Municipio	PR.
49500	38660	Guayanilla Municipio	PR.
49500	38660	Peñuelas Municipio	PR.
49500	38660	Yauco Municipio	PR.

v. Transition Period

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

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

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

Addendum A provides a crosswalk between the FY 2016 wage index using the current OMB delineations in effect in FY 2015 and the FY 2016 wage index using the proposed revised OMB delineations, as well as the proposed transition wage index values that would be in effect in FY 2016 if these proposed changes are finalized. Addendum A shows each state and county and its corresponding proposed transition wage index along with the previous CBSA number, the new CBSA number, and the new CBSA name.

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

2. Proposed Hospice Payment Update Percentage

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

Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html.

In addition to the MFP adjustment, section 3401(g) of the Affordable Care Act also mandates that in FY 2013 through FY 2019, the hospice payment update percentage will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act). The proposed hospice payment update percentage for FY 2016 is based on the estimated inpatient hospital market basket update of 2.7 percent (based on IHS Global Insight, Inc.'s first quarter 2015 forecast with historical data through the fourth quarter of 2014). Due to the requirements at 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the estimated inpatient hospital market basket update for FY 2016 of 2.7 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.6 percentage point for FY 2016). The estimated inpatient hospital market basket update for FY 2016 is reduced further by a 0.3 percentage point, as mandated by the Affordable Care Act. In effect, the proposed hospice payment update percentage for FY 2016 is 1.8 percent. We are also proposing that if more recent data are subsequently available (for example, a more recent estimate of the inpatient hospital market basket update and MFP adjustment), we would use such data, if appropriate, to determine the FY 2016 market basket update and the MFP adjustment in the FY 2016 Hospice Rate Update final rule.

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

3. Proposed FY 2016 Hospice Payment Rates

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

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

As discussed in section III.B.2, of this proposed rule, we are proposing two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 60 and beyond. As discussed in section III.B.3, we are proposing to make a SIA payment, in addition to the daily RHC payment, when direct patient care is provided by a RN or social worker during the last 7 days of the patient's life. The SIA payment would be equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the day of service. The SIA payment would also be adjusted by the appropriate wage index. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, for the proposed SIA payment, the proposed RHC rates would need to be adjusted by a budget neutrality factor. The budget neutrality adjustment that would apply to days 1 through 60 is equal to 1 minus the ratio of SIA payments for days 1 through 60 to the total payments for days 1 through 60 and is calculated to be 0.9853. The budget neutrality adjustment that would apply to days 61 and beyond is equal to 1 minus the ratio of SIA payments for days 61 and beyond to the total payments for days 61 and beyond and is calculated to be 0.9967. Lastly, the RHC rates would be increased by the proposed FY 2016 hospice payment update percentage of 1.8 percent as discussed in section III.C.3. The proposed FY 2016 RHC rates are shown in Table 22. The proposed FY 2016 payment rates for CHC, IRC, and GIP would be the FY 2015 payment rates increased by 1.8 percent. The proposed rates for these three levels of care are shown in Table 23. The proposed FY 2016 rates for hospices that do not submit the required quality data are shown in Tables 24 and 25. The proposed FY 2016 hospice payment rates would be effective for care and services furnished on or after October 1, 2015, through September 30, 2016.

TABLE 22—PROPOSED FY 2016 HOSPICE PAYMENT RATES FOR RHC

Code	Description	Proposed rates [1]	Proposed SIA budget neutrality factor adjustment (1–0.0081)	Proposed FY 2016 hospice payment update percentage	Proposed FY 2016 payment rates
651	Routine Home Care (days 1–60)	$187.63	× 0.9853	× 1.018	$188.20
651	Routine Home Care (days 61+)	145.21	0.9967	× 1.018	147.34

[1] See section III.B.2 for the proposed RHC rates for days 1–60, and days 61 and beyond before accounting for the proposed Service Intensity Add-on (SIA) payment budget neutrality factor and the proposed FY 2016 hospice payment update percentage of 1.8 percent as required by section 1814(i)(1)(C) of the Act.

TABLE 23—PROPOSED FY 2016 HOSPICE PAYMENT RATES FOR CHC, IRC, AND GIP

Code	Description	FY 2015 payment rates	Proposed FY 2016 hospice payment update of 1.8 percent	Proposed FY 2016 payment rate
652	Continuous Home Care Full Rate = 24 hours of care $=39.44 FY 2016 hourly rate	$929.91	× 1.018	$946.65
655	Inpatient Respite Care	164.81	× 1.018	167.78
656	General Inpatient Care	708.77	× 1.018	721.53

We reiterate in this proposed rule, that the Congress required in sections 1814(i)(5)(A) through (C) of the Act that hospices begin submitting quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index final rule (76 FR 47320 through 47324), we implemented a Hospice Quality Reporting Program (HQRP) as required by section 3004 of the Affordable Care Act. Hospices were required to begin collecting quality data in October 2012, and submit that quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. We remind hospices that this applies to payments in FY 2016 (See Tables 24 and 25 below). For more information on the HQRP requirements please see section III.E. in this proposed rule.

TABLE 24—PROPOSED FY 2016 HOSPICE PAYMENT RATES FOR RHC FOR HOSPICES THAT *DO NOT* SUBMIT THE REQUIRED QUALITY DATA

Code	Description	Proposed RHC rates [1]	Proposed SIA budget neutrality factor adjustment (1–0.0081)	Proposed FY 2016 hospice payment update of 1.8 percent minus 2 percentage points = −0.2 percent	Proposed FY 2016 payment rates
651	Routine Home Care (days 1–60)	$187.63	× 0.9853	× 0.998	$184.50
651	Routine Home Care (days 61+)	145.21	0.9967	× 0.998	144.44

[1] See section III.B.2 for the proposed RHC rates for days 1–60, and days 61 and beyond before accounting for the proposed Service Intensity Add-on (SIA) payment budget neutrality factor and the proposed FY 2016 hospice payment update percentage of 1.8 percent as required by section 1814(i)(1)(C) of the Act.

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

Code	Description	FY 2015 payment rates	Proposed FY 2016 hospice payment update of 1.8 percent minus 2 percentage points = −0.2 percent	Proposed FY 2016 payment rate
652	Continuous Home Care Full Rate= 24 hours of care $=38.67 hourly rate.	$929.91	× 0.998	$928.05
655	Inpatient Respite Care	164.81	× 0.998	164.48
656	General Inpatient Care	708.77	× 0.998	707.35

4. Hospice Aggregate Cap and the IMPACT Act of 2014

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

The aggregate cap amount was set at $6,500 per beneficiary when first enacted in 1983; this was an amount hospice advocates agreed was well above the average cost of caring for a hospice patient.[52] Since 1983, the

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

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

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

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

In accordance with section 1814(i)(2)(B)(i) of the Act, the hospice aggregate cap amount for the 2015 cap year, starting on November 1, 2014 and ending on October 31, 2015, will be $27,135.96. This amount was calculated by multiplying the original cap amount of $6,500 by the change in the CPI–U medical care expenditure category, from the fifth month of the 1984 accounting year (March 1984) to the fifth month the current accounting year (in this case, March 2015). The CPI–U for medical care expenditures for 1984 to present is available from the Bureau of Labor Statistics (BLS) Web site at: *http://www.bls.gov/cpi/home.htm.*

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

Step 2: Divide the March 2015 CPI–U for medical care expenditures by the 1984 CPI–U for medical care expenditures to compute the change.

440.020/105.4 = 4.174763

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

$6,500 × 4.174763 = $27,135.96

As required by section 1814(i)(2)(B)(ii) of the Act, the hospice aggregate cap amount for the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016, will be the 2015 cap amount updated by the FY 2016 hospice payment update percentage (see section III.C.2 above). As such, the 2016 cap amount will be $27,624.41 ($27,135.96 * 1.018 = $27,624.41). A Change Request with the finalized hospice payment rates, a finalized hospice wage index, the Pricer for FY 2016, and the hospice cap amount for the cap year ending October 31, 2015 will be issued in the summer.

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

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

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

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

During FY 2012 rulemaking, in addition to the streamlined method, CMS added a ''patient-by-patient proportional'' method as a way of calculating the number of Medicare beneficiaries who received hospice services during the year in determining the aggregate cap amount for any given hospice (76 FR 47309). This method specifies that a hospice should include in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. The total number of Medicare beneficiaries for a given hospice's cap year is determined by summing the whole or fractional share of each Medicare beneficiary that received hospice care during the cap year, from that hospice. Under the patient-by-patient proportional methodology, the timeframe for counting the number of Medicare beneficiaries is the same as the cap accounting year (November 1 through October 31). The aggregate cap amount for each hospice is now calculated using the patient-by-patient proportional method, except for those hospices that had their cap determination calculated under the streamlined method prior to the 2012 cap year, did not appeal the streamlined method used to determine

the number of Medicare beneficiaries used in the aggregate cap calculation, and opted to continue to have their hospice aggregate cap calculated using the streamlined method no later than 60 days after receipt of its 2012 cap determination

2. Proposed Inpatient and Aggregate Cap Accounting Year Timeframe

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

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

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

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

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

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

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

1. Background and Statutory Authority

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

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

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

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

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

Quality measures may be considered for removal by CMS if:

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

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

measure will be formally announced in the next annual rulemaking cycle.

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

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

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

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

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

Hospices are required to complete and submit an HIS-Admission and an HIS-Discharge record for each patient admission. Hospices failing to report quality data via the HIS in FY 2015 will have their market basket update reduced by 2 percentage points in FY 2017 beginning in October 1, 2016. In the FY 2015 Hospice Wage Index final rule (79 FR 50485, 50487), we finalized the proposal to codify the HIS submission requirement at § 418.312. The System of Record (SOR) Notice titled ''Hospice Item Set (HIS) System,'' SOR number 09–70–0548, was published in the **Federal Register** on April 8, 2014 (79 FR 19341).

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

We are not currently proposing any new measures for FY 2017. However, we are working with our measure development and maintenance contractor to identify measure concepts for future implementation in the HQRP. In identifying priority areas for future measure enhancement and development, CMS takes into consideration input from numerous stakeholders, including the Measures Application Partnership (MAP), the Medicare Payment Advisory Commission (MedPAC), Technical Expert Panels, and national priorities, such as those established by the National Priorities Partnership, the HHS Strategic Plan, the National Strategy for Quality Improvement in Healthcare, and the CMS Quality Strategy. In addition, CMS takes into consideration vital feedback and input from research published by our payment reform contractor as well as from the Institute of Medicine (IOM) report, titled ''Dying in America,'' released in September 2014.[53] Finally, the current HQRP measure set is also an important consideration for future measure development areas; future measure development areas should complement the current HQRP measure set, which includes HIS measures and CAHPS® Hospice Survey measures. Based on input from stakeholders, CMS has identified several high priority concept areas for future measure development:

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

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

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

a. Background

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

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

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50488) we finalized a policy stating that any hospice that receives its CCN notification letter on or after November 1 of the preceding year involved is excluded from any payment penalty for quality reporting purposes for the following FY. For example, if a hospice provider receives their CCN notification letter on November 2, 2015 they would

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

not be required to submit quality data for the current reporting period ending December 31, 2015 (which would affect the FY 2017 APU). In this instance, the hospice would begin with the next reporting period beginning January 1, 2016 and all subsequent years. However, if a hospice provider receives their CCN notification letter on October 31, 2015, they would be required to submit quality data for the current reporting period ending December 31, 2015 (which would affect the FY 2017 APU) and all subsequent years. This requirement was codified at § 418.312.

We are proposing to modify our policies for the timing of new providers to begin reporting to CMS. Beginning with the FY 2018 payment determination and for each subsequent payment determination, we propose that a new hospice be responsible for HQRP quality data reporting beginning on the date they receive their Certification Number (CCN) (also known as the Medicare Provider Number) notification letter from CMS. Under this proposal, hospices would be responsible for reporting quality data on patient admissions beginning on the date they receive their CCN notification.

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

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

In the FY 15 Hospice Wage Index final rule (79 FR 50486) we finalized our policy requiring that, for the FY 2017 reporting requirements, hospices must complete and submit HIS records for all patient admissions to hospice on or after July 1, 2014. Electronic submission is required for all HIS records. Although electronic submission of HIS records is required, hospices do not need to have an electronic medical record to complete or submit HIS data. In the FY 14 Hospice Wage Index (78 FR 48258) we finalized that, to complete HIS records, providers can use either the Hospice Abstraction Reporting Tool (HART) software, which is free to download and use, or a vendor-designed software. HART provides an alternative option for hospice providers to collect and maintain facility, patient, and HIS Record information for subsequent submission to the QIES ASAP system. Once HIS records are complete, electronic HIS files must be submitted to CMS via the QIES ASAP system. Electronic data submission via the QIES ASAP system is required for all HIS submissions; there are no other data submission methods available. Hospices have 30 days from a patient admission or discharge to submit the appropriate HIS record for that patient through the QIES ASAP system. CMS will continue to make HIS completion and submission software available to hospices at no cost. We provided details on data collection and submission timing at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html*.

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

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

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

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

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

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

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

In order to accurately analyze quality reporting data received by hospice providers, it is imperative we receive ongoing and timely submission of all HIS-Admission and HIS-Discharge records. To date, the timeliness criteria for submission of HIS Admission and HIS-Discharge records has never been proposed and finalized through rulemaking process. We believe this

matter should be addressed by defining a clear standard for timeliness and compliance at this time. In response to input from our stakeholders seeking additional specificity related to HQRP compliance affecting FY payment determinations and, due to the importance of ensuring the integrity of quality data submitted to CMS, we are proposing to set specific HQRP thresholds for timeliness of submission of hospice quality data beginning with data affecting the FY 2018 payment determination and subsequent years.

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

For example, beginning in FY 2018, hospices will have met the timeliness requirement threshold if at the end of the reporting period 70 percent of all their HIS reporting data for the year has been received within the 30 day submission timeframe.

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

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

We invite public comment on our proposal to implement the new data submission and compliance threshold requirement, as described previously, for the HQRP.

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

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

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

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

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

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

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

quality reporting (79 FR 50450 also refer to 78 FR 48261).

a. Background and Description of the Survey

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

CMS developed the CAHPS® Hospice Survey with input from many stakeholders, including other government agencies, industry stakeholders, consumer groups and other key individuals and organizations involved in hospice care. The Survey was designed to measure and assess the experiences of patients who died while receiving hospice care as well as the experiences of their informal caregivers. The goals of the survey are to—

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

The development process for the survey began in 2012 and included a public request for information about publicly available measures and important topics to measure (78 FR 5458, January 25, 2013); a review of the existing literature on tools that measure experiences with end-of-life care; exploratory interviews with caregivers of hospice patients; a technical expert panel attended by survey development and hospice care quality experts; cognitive interviews to test draft survey content; incorporation of public responses to **Federal Register** notices (78 FR 48234, August 7, 2013) and a field test conducted by CMS in November and December 2013.

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

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

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

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

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

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

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

The CAHPS® Hospice Survey includes the measures detailed in Table 27. The individual survey questions that comprise each measure are listed under the measure. These measures are in the process of being submitted to the National Quality Forum (NQF).

Table 27—Hospice Experience of Care Survey Quality Measures and Constituent Items

Hospice team communication
- While your family member was in hospice care, how often did the hospice team keep you informed about when they would arrive to care for your family member?
- While your family member was in hospice care, how often did the hospice team explain things in a way that was easy to understand?
- How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?
- While your family member was in hospice care, how often did the hospice team keep you informed about your family member's condition?
- While your family member was in hospice care, how often did the hospice team listen carefully to you?

Getting timely care
- While your family member was in hospice care, when you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?
- How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?

Treating family member with respect
- While your family member was in hospice care, how often did the hospice team treat your family member with dignity and respect?
- While your family member was in hospice care, how often did you feel that the hospice team really cared about your family member?

Providing emotional support
- While your family member was in hospice care, how much emotional support did you get from the hospice team?
- In the weeks after your family member died, how much emotional support did you get from the hospice team?

Getting help for symptoms
- Did your family member get as much help with pain as he or she needed?
- How often did your family member get the help he or she needed for trouble breathing?
- How often did your family member get the help he or she needed for trouble with constipation?
- How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness?

Getting hospice care training
- Did the hospice team give you the training you needed about what side effects to watch for from pain medicine?
- Did the hospice team give you the training you needed about if and when to give more pain medicine to your family member?
- Did the hospice team give you the training you needed about how to help your family member if he or she had trouble breathing?
- Did the hospice team give you the training you needed about what to do if your family member became restless or agitated?

Single Item Measures

Providing support for religious and spiritual beliefs
- (Support for religious or spiritual beliefs includes talking, praying, quiet time, or other ways of meeting your religious or spiritual needs.) While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?

Information continuity
- While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member's condition or care?

Understanding the side effects of pain medication
- Side effects of pain medicine include things like sleepiness. Did any member of the hospice team discuss side effects of pain medicine with you or your family member?

Global Measures

Overall rating of hospice
- Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member's hospice care?

Recommend hospice
- Would you recommend this hospice to your friends and family?

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

Approved CAHPS® Hospice Survey vendors will submit data on the hospice's behalf to the CAHPS® Hospice Survey Data Center. The deadlines for data submission occur quarterly and are shown in Table 28 below. Deadlines are the second Wednesday of the submission months, which are August, November, February, and May. Deadlines are final; no late submissions will be accepted. However, in the event of extraordinary circumstances beyond the control of the provider, the provider will be able to request an exemption as previously noted in the Quality Measures for Hospice Quality Reporting Program and Data Submission Requirements for Payment Year FY 2016 and Beyond section. Hospice providers are responsible for making sure that their vendors are submitting data in a timely manner.

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

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

[1] Data collection for each sample month initiates two months following the month of patient death (for example, in April for deaths occurring in January).
[2] Data submission deadlines are the second Wednesday of the submission month.
[2] Corrected from the Final Rule published August 22, 2014, 79 FR 50493.

In the FY 2014 Hospice Wage Index and Rate Update final rule, we stated that we would exempt very small hospices from CAHPS® Hospice Survey requirements. We propose to continue that exemption: Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2015 through December 31, 2015 are exempt from CAHPS® Hospice Survey data collection and reporting requirements for the 2018 APU. To qualify for the survey exemption for the FY 2018 APU, hospices must submit an exemption request form. This form will be available on the CAHPS® Hospice Survey Web site *http://www.hospicecahpssurvey.org.* Hospices are required to submit to CMS their total unique patient count for the period of January 1, 2015 through December 31, 2015. The due date for submitting the exemption request form for the FY 2018 APU is August 10, 2016.

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

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

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

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

d. Annual Payment Update

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

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

e. CAHPS® Hospice Survey Oversight Activities

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

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

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

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

We wish to clarify that any hospice that wishes to submit a reconsideration request must do so by submitting an email to CMS containing all of the requirements listed on the HQRP Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html.* Electronic email sent to *HQRPReconsiderations@cms.hhs.gov* is the only form of submission that will be accepted. Any reconsideration requests received through any other channel including U.S. postal service or phone will not be considered as a valid reconsideration request. We codified this process at § 418.312. In addition, we codified at § 418.306 that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY and solicited comments on all of the proposals and the associated regulations text at § 418.312 and in § 418.306 in section VI.

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

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

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

We invite comment on the proposals to add CASPER Reporting as an additional communication mechanism for the dissemination of compliance notifications and to publish a list of compliant hospices on the HQRP Web site.

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

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any quality data submitted by hospices available to the public. The procedures must ensure that a hospice would have the opportunity to review the data regarding the hospice's respective program before it is made public.

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

In addition, the Affordable Care Act requires that reporting be made public on a CMS Web site and that providers have an opportunity to review their data prior to public reporting. CMS will develop the infrastructure for public reporting, and provide hospices an opportunity to review their quality measure data prior to publicly reporting information about the quality of care provided by ''Medicare-certified'' hospice agencies throughout the nation. CMS also plans to make available provider-level feedback reports in the Certification and Survey Provider Enhances Reports (CASPER) system. These provider-level feedback reports or ''quality reports'' will be separate from public reporting and will be for provider viewing only, for the purposes of internal provider quality improvement. As is common in other quality reporting programs, quality reports would contain feedback on facility-level performance on quality metrics, as well as

benchmarks and thresholds. For the CY 2014 Reporting Cycle, there were no quality reports available in CASPER; however, CMS anticipates that provider-level quality reports will begin to be available sometime in CY 2015. CMS anticipates that providers would use the quality reports as part of their Quality Assessment and Performance Improvement (QAPI) efforts.

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

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

F. Clarification Regarding Diagnosis Reporting on Hospice Claims

1. Background

During the grass roots movement of hospice growth in the United States in the 1970s, healthcare providers recognized the need for a care delivery model to address the needs of those individuals who no longer wanted to seek out the curative care for advancing illnesses and injuries. In the early stages of development, hospice leaders worked with key legislative leaders to develop a system to reimburse hospice care in the United States.[54] However, it was evident that before governmental reimbursement could occur, data had to be collected and analyzed to demonstrate what hospices actually provided and what costs were involved in rendering hospice care. The Health Care Financing Administration (HCFA)—now known as the Centers for Medicare & Medicaid Services (CMS)—conducted a demonstration that included 26 hospices located throughout the country to study the effect of Medicare-reimbursed hospice care. The results of this demonstration, as well as those sponsored by the private health insurance sector and private foundations, along with the testimony of multiple hospice industry leaders, legislators, and hospice families, helped to form the structure of the Medicare hospice benefit. Stakeholders agreed that a Medicare hospice benefit needed to be structured to promote cost control and appropriate service provision, while discouraging providers from entering the hospice market with the intent of maximizing reimbursement from Medicare.

Both the Congress and the hospice industry wanted the Medicare hospice benefit to provide a coordinated range of services to ensure that terminally ill individuals would have access to comprehensive care aimed at addressing their physical, emotional, psychosocial and spiritual needs as they approached the end of life. As stated in the 1983 hospice final rule, and reiterated throughout hospice rules since implementation of the benefit, it is our general view that the waiver required by the law is a broad one and that hospices are required to provide virtually all the care that is needed by terminally ill patients (48 FR 56010). Therefore, hospices are to provide pain and symptom management, as an alternative to the curative model of care, focused on the ''total person'' as opposed to individual disease or injury states. 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. We continue to support the philosophy of holistic, comprehensive, virtually all-inclusive hospice care and seek to protect beneficiary access and coverage under the Medicare hospice benefit.

2. Current Discussions About Hospice Vulnerabilities

The Institute of Medicine (IOM) recently released the report, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life.* This report discussed vulnerabilities in the current health care system, especially as it relates to those who are approaching the end of life, and stated that one of the largest barriers in providing efficient, quality end-of-life care is the lack of coordination and communication among different components of the health care system.[55] The report states that better coordination of care is essential in improving patient outcomes and that end-of-life care should be individualized based on patient values, goals, needs, and informed preferences with a recognition that individual service needs and intensity will change over time.[56]

Recent news articles on hospice care highlight the same concerns expressed in the IOM report regarding vulnerabilities in the current health care system. While recent news articles agree that hospice care is a valuable and needed service for patients who are near death, the articles identified issues with hospice quality of care, the lack of services provided, conflicts of interest, and the current Medicare payment structure that may incentivize the provision of fewer services.[57] Overall, the IOM report and recent news articles raise concerns regarding fragmented and uncoordinated care for those who are terminally ill.

As mentioned in previous rules, and in section III.A of this proposed rule, there is data suggesting a significant amount of ''unbundling'' is occurring for services that should be included in the hospice bundled payment. As

[54] Connor, S. (2007). *Development of Hospice and Palliative Care in the United States.* OMEGA. 56 (1); 89–99.

[55] Institute of Medicine (IOM), ''Dying in America: Improving Quality and Honoring Individual Preferences Near End-of-Life,'' 2014, p.5–10.

[56] Institute of Medicine (IOM), ''Dying in America: Improving Quality and Honoring Individual Preferences Near End-of-Life,'' 2014, p.5–52.

[57] *http://www.washingtonpost.com/sf/business/collection/business-of-dying/*

discussed previously above, our data analysis shows that $1.3 billion is being paid outside of the Medicare hospice benefit for those under an active hospice election. With such a significant amount of services being provided outside of the Medicare hospice benefit, it raises questions whether hospices are providing full disclosure of the nature of hospice care, which focuses on improving quality of life as one is approaching the end of life while eliminating the need for unnecessary, futile and possibly harmful diagnostics, treatments, and therapies. Additionally, we have received anecdotal reports from non-hospice providers who have rendered care and services to hospice beneficiaries in which the non-hospice provider states that the care given was related to the terminal prognosis of the individual. These reports go on to say that they have contacted hospices to coordinate the care of the hospice beneficiary only to be told by those hospices that they disagreed with the non-hospice providers' clinical judgment that the care was related to the terminal prognosis. We have been told that hospices are refusing to reimburse the non-hospice provider for care related to the terminal prognosis. These non-hospice providers also informed us that the hospices told them to code the claim with a different diagnosis or to code condition code 07 (treatment of Non-terminal Condition for Hospice) or the modifier ''GW'' (service not related to the hospice patient's terminal condition) on their claims to ensure that the non-hospice provider would consequently get paid through Medicare. These non-hospice providers stated that they disagreed with this practice, and considered it fraudulent. As such, they were unable to be reimbursed by the hospice or by Medicare for services provided that they felt were the responsibility of hospice. We have also received anecdotal reports from hospice beneficiaries and their families that they have been told by the hospice to revoke their hospice election to receive high-cost services that should be covered by the hospice, such as palliative chemotherapy and radiation.

Given the legislative history, the statements provided by hospices during the development of the benefit, and anecdotal reports from non-hospice providers and hospice beneficiaries, we are concerned that some hospices are making determinations of hospice coverage based solely on cost and reimbursement as opposed to being based on patient-centered needs, preferences and goals for those approaching the end of life. We believe this to be counter to the holistic, comprehensive, and coordinated hospice care model promoted during the development of the Medicare hospice benefit.[58] It was very clear throughout the development, and years after the implementation, of the Medicare hospice benefit that hospices were expected to make good on their promise to do a better job in the provision and coordination of care than conventional Medicare services for those who were at the end of life.[59] However, if hospices are not making good on that promise, it results in increased burden on hospice beneficiaries and their families—both clinically and financially—and is not in keeping with the intent of the Medicare hospice benefit as originally developed and implemented in 1983.

3. Medicare Hospice Eligibility Requirements

The Medicare hospice regulations at § 418.25(b) state that in reaching a decision to certify that a patient is terminally ill, meaning that the patient has a medical prognosis of a life expectancy of 6 months or less, the certifying physician(s) must consider at least the following information:

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

Eligibility for the Medicare hospice benefit has always been based on the prognosis of the individual. As we have mentioned in previous rules, prognosis is not necessarily established through just a single diagnosis or even multiple diagnoses; rather, it is based on the totality of the individual and everything that affects their life expectancy. In the FY 2015 Hospice Payment Rate Update final rule (79 FR 50471), we reminded providers that there are multiple public sources available to assist in determining whether a patient meets Medicare hospice prognosis eligibility criteria (that is, industry-specific clinical and functional assessment tools and information on MAC Web sites, including Local Coverage Determinations (LCDs)). We have mentioned that there are prognostication tools available for hospices to assist in thoughtful evaluation of Medicare beneficiaries for determining eligibility for the Medicare hospice benefit. We expect hospice providers to use the full range of tools available, including guidelines, comprehensive assessments, and the complete medical record, as necessary, to make responsible and thoughtful clinical determinations regarding prognosis eligibility.

As mentioned earlier in this section, the hospice industry has come under increased media scrutiny, much of it related to hospices enrolling patients who may not be eligible for the benefit because they are not terminally ill and enrolling patients with certain diagnoses that typically have a longer length of stay, mainly non-cancer diagnoses. In the December 26, 2013 Washington Post article, ''Hospice firms draining billions from Medicare'', the author discusses the incentives for hospices to recruit patients who are not yet terminally ill or not yet ready to elect the hospice benefit. This article also goes on to describe allegations from former hospice employees who say that some hospices knowingly admitted patients who were not declining in health.[60] To address some of these noted hospice vulnerabilities, the recent IMPACT Act legislation, as summarized in Section II.D.8. of this proposed rule, requires increased hospice program oversight through more frequent hospice surveys and medical review efforts. All of these efforts seek to protect the Medicare hospice beneficiaries, as well as, the integrity of the Medicare hospice benefit.

4. Assessment of Conditions and Comorbidities Required by Regulation

We have recognized throughout the federal regulations at part 418 that the total person is to be assessed, including acute and chronic conditions, as well as, controlled and uncontrolled conditions, and comorbidities, in order to determine an individual's terminal prognosis. We have also been clear that the original intent of the Medicare hospice benefit is to provide comprehensive, integrated and holistic care for those who have a terminal prognosis. While hospices are responsible for the palliation and management of the terminal illness and related conditions, in the 1983 hospice proposed rule (48 FR 38147) we stated that upon hospice election, the individual waives payment for certain other benefits except in ''exceptional and unusual circumstances.'' In that

[58] ''Background Materials on Medicare Hospice Benefit Including Description of Proposed Implementing Regulations,'' September 9, 1983. Committee on Finance, United States Senate, S. Prt. 98–88, p. 1.

[59] Hoyer, T. (1998). A History of the Medicare Hospice Benefit. The Hospice Journal, 13(1–2), 61–69.

[60] *http://www.washingtonpost.com/business/economy/medicare-rules-create-a-booming-business-in-hospice-care-for-people-who-arent-dying/2013/12/26/4ff75bbe-68c9-11e3-ae56-22de072140a2_story.html.*

proposed rule, we did not specify these ''exceptional and unusual circumstances'' because we did not yet know what specific types of circumstances would warrant the use of this exception and invited comments on this point. In the 1983 hospice final rule (48 FR 56010 through 56011), we stated that we did not receive any suggestions for identifying exceptional and unusual circumstances that warranted the inclusion of a specific provision in the regulations to accommodate them. We stated this because most of the comments that were made attempted to suggest this exception as a means of routinely providing non-hospice Medicare financing for the expense of costly services needed by hospice patients and we do not view this as an appropriate interpretation of the law (48 FR 56011). We reiterated that we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case by case basis and that it is our general rule that the waiver required by law is a broad one.

Since the implementation of the Medicare hospice benefit, there have been many questions and requests for CMS to provide those ''exceptional and unusual'' circumstances for which a condition would be unrelated to the prognosis of the terminally ill individual. We continue to state that those circumstances would be ''exceptional and unusual'' and that hospices continue to be required to provide virtually all the care that is needed by terminally ill patients. To respond to the many requests for greater clarification, in the Medicare Program; FY 2015 Payment Rate Update proposed rule (79 FR 26554 through 26555), we solicited comments on definitions we provided for ''terminal illness'' and ''related conditions.'' Based on comments received in response to those definitions and from comments received in prior year's proposed rules, it appears that there continues to be widely varying interpretation as to what constitutes ''terminal illness'' and ''related conditions'' and hence the services that should be provided and covered by hospices. Similar to the 1983 hospice final rule, some commenters appear to have a very broad interpretation stating that all conditions are related to the terminal prognosis. Other commenters have a very narrow interpretation as to what illnesses and conditions would be and would not be the responsibility of hospice, and felt that those conditions are limited to a single diagnosis. Additionally, some comments previously received stated that longstanding, preexisting, chronic, stable and controlled conditions and disease states as well as comorbidities, should not be considered related to a patient's terminal illness or related conditions. Some commenters went on to say that not all pain and symptoms are related to a patient's terminal prognosis. Many commenters stated that determining ''related conditions'' was often very difficult, while others reported that it wasn't difficult at all. Many commenters felt that the management and maintenance of comorbidities is not the responsibility of hospice as they felt that these comorbidities are not related to the reason why an individual is terminally ill. These commenters believed that these types of conditions should not be included in the bundle of services covered under the Medicare hospice benefit. As we have previously stated in response to those comments, we believe these conditions are included in the bundle of hospice services as hospices are required to provide reasonable and necessary services for both palliation and management of all conditions that contribute to a terminal prognosis. Conversely, several commenters were in agreement that all medical problems will affect a person's prognosis and will relate, in some way, to the disease that will ultimately end that person's life.

Defined at § 418.3, ''terminally ill'' means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. The original implementing regulations of the Medicare hospice benefit, beginning with the 1983 hospice propose and final rules (48 FR 318146 and 48 FR 56008), articulate a set of requirements that do not delineate between preexisting, chronic, controlled or comorbid conditions. The presence of comorbidities is recognized as an important factor contributing to the overall status of an individual and should be considered when determining terminal prognosis. Mental health comorbidities must also be considered as it is not uncommon for terminally ill individuals to have underlying mental health conditions that could contribute to their prognosis and/or affect the plan of care. Health care researchers agree the importance of comorbidity is clear, due to its high prevalence in older populations and its impact on health and health care.[61] It is also well-documented that comorbidities affect overall general health, treatment choice, prognosis, and is a predictor of poor survival.[62] A study of U.S. hospice patients also showed that hospice patients with higher comorbidity index scores were more likely to—

- Be admitted to the ER and hospital;
- Die in the hospital;
- Be discharged from hospice.[63]

It is not an uncommon clinical practice for some clinicians to stop drugs for comorbid conditions arbitrarily because the person has a progressive life-limiting illness; however, withdrawing long term drugs from comorbidities without considering the natural course of the illness can lead to serious problems, such as rebound hypertension, tachycardia, depression and death.[64] It is imperative for hospice patients with comorbidities to have careful management and for clinicians to consider both the physical and psychological effects of treatment.[65]

The National Hospice and Palliative Care Organization (NHPCO) recognizes the importance of comorbidities. They define ''comorbidity'' as known factors or pathological disease impacting on the primary health problem and generally attributed to contributing to increased risk for poor health status outcomes[66] This aligns with the Medicare hospice benefit requirements in which the physical, psychosocial, emotional and spiritual needs of the individual and his or her family must be assessed to develop the hospice plan of care. The individualized plan of care is developed and refined, as necessary, through the course of an individual's hospice election and is based on the initial and ongoing comprehensive assessments.

[61] Gijsen, R., Hoeymans, N., Schellevis, F., Ruwaard, Satariano, W., van den Bos, G., (2001). Causes and consequences of comorbidity: A review. Journal of Clinical Epidemiology, 54(2001), 661.

[62] Yancik, R., Ganz, P, Varricchio, C., Conley, B. (2001). Perspectives on Comorbidity and Cancer in Older Patients: Approaches to Expand the Knowledge Base. American Society of Clinical Oncology. PAGE #.

Repetto, L., Comandini, D., Mammoliti, S. (2001). Life expectancy, comorbidity and quality of life: The treatment equation in the older cancer patients. Critical Reviews in Oncology/Hematology, 37(2001), 148.

Escarrabill, J., Cataluna, J., Hernandez, C., Servera, E. (2009). Recommendations for End-of-Life Care in Patients with Chronic Obstructive Pulmonary Disease. Archivos de Bronconeumologia, 45(6), 297–303.

[63] Legler et al. (2011). The effect of comorbidity burden on health care utilization for patients with cancer using hospice. Journal of Palliative Care Medicine. 14(6), 751–756.

[64] Stevenson, J., Abernethy, A., Miller, C, Currow, D. (2004). Managing comorbidities in patients at the end of life. British Medical Journal. 324(2004), 909–912.

[65] Stevenson, J., Abernethy, A., Miller, C, Currow, D. (2004). Managing comorbidities in patients at the end of life. British Medical Journal. 324(2004), 909–912.

[66] National Hospice and Palliative Care Organization. (2010). Standards of Practice for Hospice Programs.

Our regulations at § 418.54(c) require that the comprehensive assessment must take into consideration the following factors:

- The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
- Complications and risk factors that affect care planning.
- Functional status, including the patient's ability to understand and participate in his or her own care.
- Imminence of death.
- Severity of symptoms.
- Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy.
- Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.
- The need for referrals and further evaluation by appropriate health professionals.

The hospice CoPs at § 418.56(c) require that the hospice plan of care reflect patient and family goals and have measurable outcomes. Furthermore, the plan of care is a dynamic and fluid document that will change as the individual's condition changes throughout the course of a hospice election. A comprehensive, holistic, integrated and coordinated approach to service delivery is the hallmark of hospice care and a valued service for Medicare beneficiaries and families as the individual approaches the end-of-life. We believe that many hospices practice this comprehensive approach as they recognize that it is the hospices' responsibility to provide all medical, emotional, psychosocial and spiritual services for all component conditions of the terminal prognosis along the continuum of care.

5. Clarification Regarding Diagnosis Reporting on Hospice Claims

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD–10–CM) Coding Guidelines state the following regarding the selection of the principal diagnosis: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. In the case of selection of a principal diagnosis for hospice care, this would mean the diagnosis most contributory to the terminal prognosis of the individual. In the instance where two or more diagnoses equally meet the criteria for principal diagnosis, ICD–10–CM coding guidelines do not provide sequencing direction, and thus, any one of the diagnoses may be sequenced first, meaning to report all of those diagnoses meeting the criteria as a principal diagnosis. Per ICD–10–CM Coding Guidelines, for diagnosis reporting purposes, the definition for ''other diagnoses'' is interpreted as additional conditions that affect patient care in terms of requiring:

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

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

However, though established coding guidelines are required, it does not appear that all hospices are coding on hospice claims per these guidelines. In 2010, over 77 percent of hospice claims reported only one diagnosis. Previous rules have discussed requirements for hospice diagnosis reporting on claims and the importance of complete and accurate coding. Preliminary analysis of FY 2014 claims data demonstrates that hospice diagnosis coding is improving; however, challenges remain. Analysis of FY 2014 claims data indicates that 49 percent of hospice claims listed only one diagnosis.[67] We conducted additional analysis on instances where only one diagnosis was reported on the FY 2014 hospice claim and found that 50 percent of these beneficiaries had, on average, eight or more chronic conditions and 75 percent had, on average, five or more chronic conditions.[68] These chronic, comorbid conditions include: Hypertension, anemia, congestive heart failure, chronic obstructive pulmonary disease, ischemic heart disease, depression, diabetes and atrial fibrillation, to name a few.

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

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

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

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

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

ICD–10–CM Coding Guidelines state that diagnoses should be reported that develop subsequently, coexist or affect the treatment of the individual. Furthermore, having these diagnoses reported on claims falls under the authority of the Affordable Care Act for the collection of data to inform hospice payment reform. Section 3132 a(1)(C) of the Affordable Care Act states that the Secretary may collect the additional data and information on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate. Having adequate data on hospice patient characteristics will help to inform thoughtful, appropriate, and clinically relevant policy for future rulemaking. We will monitor compliance with required coding practices and collaborate with all relevant CMS components to determine whether further policy changes are needed or if additional program integrity oversight actions need to be implemented.

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

V. Regulatory Impact Analysis

A. Statement of Need

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

B. Introduction

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

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

C. Overall Impact

The overall impact of this proposed rule is an estimated net increase in Federal Medicare payments to hospices of $200 million, or 1.3 percent, for FY 2016. The $200 million increase in estimated payments for FY 2016 reflects the distributional effects of the 1.8 percent proposed FY 2016 hospice payment update percentage ($290 million increase), the use of updated wage index data and the phase-out of the wage index budget neutrality adjustment factor (-0.7 percent/$120 million decrease) and the proposed implementation of the new OMB CBSA delineations for the FY 2016 hospice wage index with a one-year transition (0.2 percent/$30 million increase). The elimination of the wage index budget neutrality adjustment factor (BNAF) was part of a 7-year phase-out that was finalized in the FY 2010 Hospice Wage Index final rule (74 FR 39384), and is not a policy change. The proposed RHC rates and the proposed SIA payment, outlined in section III.B, would be implemented in a budget neutral manner in the first year of implementation, as required per section 1814(i)(6)(D)(ii) of the Act. In section III.B., we also proposed continuing to make the SIA payments budget neutral annually. The RHC rate budget neutrality factors and the SBNF used to reduce the overall RHC rate are outlined in section III.C.3. Therefore, the proposed RHC rates and the proposed SIA payment would not result in an overall payment impact for the Medicare program or hospices.

1. Detailed Economic Analysis

Table 29, Column 3 shows the combined effects of the use of updated wage data (the FY 2015 pre-floor, pre-reclassified hospital wage index) and the phase-out of the BNAF (for a total BNAF reduction of 100 percent), resulting in an estimated decrease in FY 2016 payments of 0.7 percent ($ − 120 million). Column 4 of Table 29, shows the effects of the proposed 50/50 blend of the FY 2016 hospice wage index values (based on the use of FY 2015 pre-floor, pre-reclassified hospital wage index data) under the old and the new CBSA delineations, resulting in an estimated increase in FY 2016 payments of 0.2 percent ($30 million). Column 5 displays the estimated effects of the proposed RHC rates, resulting in no overall change in FY 2016 payments for hospices as this proposal would be implemented in a budget neutral manner. Column 6 shows the estimated effects of the proposed SIA payment, resulting in no change in FY 2016

payments for hospices as this proposal would be implemented in a budget neutral manner through a reduction to the overall RHC rate for FY 2016. Column 7 shows the effects of the proposed FY 2016 hospice payment update percentage. The proposed 1.8 percent hospice payment update percentage is based on a 2.7 percent inpatient hospital market basket update for FY 2016 reduced by a 0.6 percentage point productivity adjustment and by 0.3 percentage point as mandated by the Affordable Care Act. The estimated effects of the 1.8 percent proposed hospice payment update percentage would result in an increase in payments to hospices of approximately $290 million. Taking into account the 1.8 percent proposed hospice payment update percentage ($290 million increase), the use of updated wage data and the phase-out of the BNAF (−$120 million), and the proposed adoption of the new OMB CBSA delineations with a one-year transition for the FY 2016 hospice wage index ($30 million), Column 8 shows that hospice payments are estimated to increase by $200 million ($290 million − $120 million + $30 million = $200 million), or 1.3 percent, in FY 2016.

a. Effects on Hospices

This section discusses our analysis of the estimated impacts on FY 2016 payments to hospices due to: (1) The use of updated wage index data for the proposed FY 2016 hospice wage index (using FY 2015 hospital pre-floor, pre-reclassified hospital wage data) and the phase-out of the BNAF, (2) the proposed FY 2016 hospice wage index that adopts the new OMB CBSA delineations with a one-year transition, (3) the proposed RHC rates, (4) the proposed SIA payment, and (5) the proposed 1.8 percent hospice payment update percentage. Table 29 below shows the results of our analysis. For the purposes of our impact analysis, we use the utilization observed in the most complete hospice claims data available at the time of rulemaking (FY 2014 hospice claims submitted as of December 31, 2014). Presenting these data gives the hospice industry a more complete picture of the effects on their total revenue based on the use of updated hospital wage index data and the BNAF phase-out, the proposed adoption of the new OMB CBSA delineations with a one-year transition, the proposed SIA payment, and the proposed FY 2016 hospice payment update percentage as discussed in this proposed rule. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

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

(1)	Providers (2)	Updated FY 2016 wage index data and phase-out of BNAF (% change) (3)	Proposed 50/50 blend of FY 2016 wage index values under old and new CBSA delineations (% change) (4)	Proposed routine home care rates (days 1 thru 60 and days 61+) (%) (5)	Proposed FY 2016 SIA payment (% change) (6)	Proposed FY 2016 hospice payment update percentage (% change) (7)	Total FY 2016 proposed policies (% change) (8)
All Hospices	4,010	−0.7	0.2	0.0	0.0	1.8	1.3
Urban Hospices	3,015	−0.7	0.3	0.0	0.0	1.8	1.4
Rural Hospices	995	−0.3	−0.2	0.4	0.0	1.8	1.7
Urban Hospices—New England	140	0.0	0.1	1.3	−0.1	1.8	3.1
Urban Hospices—Middle Atlantic	251	−0.7	−0.2	0.8	0.0	1.8	1.7
Urban Hospices—South Atlantic	410	−1.1	0.3	−0.7	−0.1	1.8	0.2
Urban Hospices—East North Central	388	−0.8	0.7	−0.2	0.0	1.8	1.5
Urban Hospices—East South Central	165	−0.7	0.5	−0.3	0.0	1.8	1.3
Urban Hospices—West North Central	221	−0.7	0.6	0.7	0.0	1.8	2.4
Urban Hospices—West South Central	593	−1.1	0.6	−1.2	−0.2	1.8	−0.1
Urban Hospices—Mountain	299	−0.6	0.2	−0.4	0.0	1.8	1.0
Urban Hospices—Pacific	511	−0.1	0.0	1.0	0.2	1.8	2.9
Urban Hospices—Outlying	37	0.0	0.3	−1.1	−0.2	1.7	0.7
Rural Hospices—New England	24	−0.3	0.0	3.3	0.3	1.8	5.1
Rural Hospices—Middle Atlantic	42	0.3	−0.1	1.8	0.5	1.8	4.3
Rural Hospices—South Atlantic	141	−0.6	0.1	−0.2	0.0	1.8	1.1
Rural Hospices—East North Central	135	−0.7	−0.4	0.8	0.2	1.8	1.7
Rural Hospices—East South Central	133	−0.1	−0.1	−0.9	−0.2	1.8	0.5
Rural Hospices—West North Central	184	−0.3	−0.1	2.2	−0.1	1.8	3.5
Rural Hospices—West South Central	184	−0.1	−0.1	−1.0	−0.2	1.8	0.4
Rural Hospices—Mountain	102	−1.4	−0.7	0.3	0.1	1.8	0.1
Rural Hospices—Pacific	47	2.1	0.1	3.3	0.3	1.8	7.6
Rural Hospices—Outlying	3	−0.8	−0.2	1.9	0.2	1.8	2.9
0–3,499 RHC Days (Small)	840	−0.5	0.1	3.0	0.1	1.8	4.5
3,500–19,999 RHC Days (Medium)	1,924	−0.6	0.2	0.6	0.0	1.8	2.0
20,000+ RHC Days (Large)	1,246	−0.7	0.3	−0.2	0.0	1.8	1.2
Non-Profit Ownership	1,070	−0.6	0.2	1.2	0.1	1.8	2.7
For Profit Ownership	2,398	−0.7	0.3	−1.0	−0.1	1.8	0.3
Govt/Other Ownership	542	−0.6	0.3	0.6	0.1	1.8	2.2
Freestanding Facility Type	3,016	−0.7	0.3	−0.4	0.0	1.8	1.0
HHA/Facility-Based Facility Type	994	−0.4	0.2	1.8	0.2	1.8	3.6
Rate of RHC NF/SNF Days is in Lowest Quartile (Less than or equal to 3.1%)	1,002	−0.5	0.1	0.7	0.0	1.8	2.1
Rate of RHC NF/SNF Days is in 2nd Quartile (Greater than 3.1 and Less than or equal to 16.7%)	1,003	−0.6	0.1	0.4	0.2	1.8	1.9
Rate of RHC NF/SNF Days is in 3rd Quartile (Greater than 16.7 and less than or equal to 35.5%)	1,003	−0.7	0.3	−0.1	0.0	1.8	1.3

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

(1)	Providers (2)	Updated FY 2016 wage index data and phase-out of BNAF (% change) (3)	Proposed 50/50 blend of FY 2016 wage index values under old and new CBSA delineations (% change) (4)	Proposed routine home care rates (days 1 thru 60 and days 61+) (%) (5)	Proposed FY 2016 SIA payment (% change) (6)	Proposed FY 2016 hospice payment update percentage (% change) (7)	Total FY 2016 proposed policies (% change) (8)
Rate of RHC NF/SNF Days is in Highest Quartile (Greater than 35.5%)	1,002	−0.7	0.4	−0.6	−0.2	1.8	0.7

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

Note: The proposed 1.8 percent hospice payment update percentage for FY 2016 is based on an estimated 2.7 percent inpatient hospital market basket update, reduced by a 0.6 percentage point productivity adjustment and by 0.3 percentage point. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in section 1814(i)(1)(C)(ii)(VII) or section 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity as set out at section 1886(b)(3)(B)(xi)(II) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under section 1814(i)(1)(C)(v) of the Act).

REGION KEY:

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

Table 29 above also presents the impact of the changes in this proposed rule according to the type of hospice, geographic location, type of ownership, hospice base, size, and percentage of RHC days in a SNF/NF. The majority of hospice payments are made at the routine home care rate; therefore, we based the size of each individual hospice's program on the number of routine home care days provided in FY 2014. As indicated in column 2 of Table 29, there are 4,010 hospices included in the regulatory impact analysis. Approximately 40 percent of Medicare-certified hospices are identified as voluntary (non-profit) or government agencies (1,612 hospices) and 60 percent are proprietary (for-profit) (2,398 hospices). In addition, our analysis shows that most hospices are in urban areas, are medium-sized, and are freestanding.

b. Hospice Size

The use of updated wage data combined with the BNAF phase-out is anticipated to decrease FY 2016 payments to large hospices by 0.7 percent and to decrease payments to small and medium hospices by 0.5 percent and 0.6 percent respectively (column 3). The proposed 50/50 Blend for FY 2016 wage index values under the old and the new CBSA delineations is anticipated to result in an increase in payments to small hospices of 0.1 percent, an increase in payments to medium hospices of 0.2 percent, and an increase to large hospices of 0.3 percent (column 4). The proposed RHC rates are projected to increase payments by 3.0 percent for small hospices and 0.6 percent for medium hospices. The proposed RHC rates are anticipated to decrease payments by 0.2 percent for large hospices. The proposed FY 2016 SIA payment is projected to result in an increase in FY 2016 payments of 0.1 percent for small hospices and no change in payments for medium and large hospices (column 6).

c. Geographic Location

Column 3 of Table 29 shows the combined estimated effects of using updated wage data and the BNAF phase-out and results in a decrease in FY 2016 payments of 0.7 percent for urban hospices and 0.3 percent for rural hospices. Urban hospices can anticipate a decrease in payments ranging from 1.1 percent in the South Atlantic and West South Central regions to 0.1 percent for hospices in the Pacific. No change in payments is expected for urban hospices in the New England and outlying areas. Rural hospices are estimated to see a decrease in payments in eight regions, ranging from 1.4 percent in the Mountain region to 0.1 percent in the East South Central and West South Central regions. Rural hospices can anticipate an increase in payments in the Middle Atlantic region of 0.3 percent and an increase of 2.1 percent in the Pacific region.

Column 4 shows the effect of the proposed 50/50 Blend of the FY2016 wage index values under the old and the new CBSA delineations. Overall, hospices are anticipated to experience a 0.2 percent increase in payments, with urban hospices experiencing an estimated increase of 0.3 percent and rural hospices experiencing an estimated decrease of 0.2 percent. All urban areas other than Middle Atlantic and Pacific are estimated to see increases in payments, ranging from 0.7 percent in the East North Central region to 0.1 percent in the New England region. No change in FY 2016 payments for hospices in urban areas in the Pacific region is expected. In contrast, rural hospices are estimated to experience a small decrease in payments in seven regions, ranging from 0.1 percent in the East South Central, Middle Atlantic, and West North Central regions to 0.7 percent in the Mountain region. Payments in the New England region are anticipated to remain unchanged and payments in the South Atlantic and Pacific regions are estimated to increase slightly by 0.1 percent.

Column 5 shows the anticipated effects of the proposed RHC rates, that is, paying separate rates for days 1 through 60 and days beyond 60. Overall, hospices would experience no change in overall payments for FY 2016 due to the proposed RHC rates. FY 2016 payments are estimated to range from an increase of 3.3 percent for rural hospices in New England and Pacific regions to a decrease of 1.2 percent for urban hospices in the West South Central region.

Column 6 shows the effects of proposed FY 2016 SIA Payment. Overall, hospices are anticipated to experience no change in overall payments for FY 2016. However, FY 2016 payments are estimated to range from an increase of 0.5 percent for rural hospices in the Middle Atlantic region to a decrease of 0.2 percent for urban hospices in the West South Central region and the Outlying region.

Column 8 shows the total anticipated impact of the FY 2016 proposed policy

changes. Overall, all hospices are anticipated to receive a 1.3 percent increase in payment. Rural hospices in the Pacific Region show the largest anticipated payment increase of 7.6 percent. Rural hospices in New England are anticipated to receive an increase of 5.1 percent, Middle Atlantic hospices are anticipated to receive an increase of 4.3 percent and rural hospices in the outlying regions are estimated to receive an increase of 2.9 percent in payments.

d. Type of Ownership

Column 3 demonstrates the effect of the use of updated wage data and BNAF phase-out on estimated FY 2016 payments. We estimate that using the updated wage data and BNAF phase-out would decrease estimated payments to voluntary (non-profit) and government hospices by 0.6 percent. Proprietary (for-profit) hospices are expected to have a decrease in payments of 0.7 percent. Column 4 demonstrates the effects of the proposed 50/50 Blend of FY 2016 wage index values under the old and the new CBSA delineations. Estimated FY 2016 payments to voluntary (non-profit), proprietary (for-profit) and government hospices are anticipated to increase by 0.2 percent, 0.3 percent and 0.3 percent, respectively. Column 5 shows the anticipated impacts for the two proposed RHC rates. Estimated FY 2016 payments are anticipated to increase for voluntary (non-profit) and government hospices by 1.2 percent and 0.6 percent respectively and to decrease for proprietary (for-profit) hospices by 1.0 percent. Column 6 shows the estimated effects of the proposed SIA payment. Estimated FY 2016 payments are anticipated to increase for voluntary (non-profit) and government hospices by 0.1 percent and decrease for proprietary (for-profit) hospices by 0.1 percent.

e. Hospice Base and Percentage of RHC Days in a SNF/NF

Column 3 demonstrates the combined effects of using the updated wage data and the BNAF phase-out on estimated payments for FY 2016. Estimated payments are anticipated to decrease for freestanding hospices by 0.7 percent and decrease for HHA/facility-based hospices by 0.4 percent. Column 4 shows the effects of the proposed 50/50 Blend of FY 2016 wage index values under the old and new CBSA delineations. Payments are estimated to increase by 0.3 percent for freestanding hospices and by 0.2 percent for HHA/facility-based hospices. Column 5 shows the effects of the proposed RHC rates. Payments to freestanding hospices are expected to decrease by 0.4 percent while payments to HHA/facility-based hospices are expected to increase by 1.8 percent. Column 6 shows the effects of the proposed SIA payment. Payments to freestanding hospices are expected to neither increase nor decrease due to the SIA proposal, while payments for HHA/facility-based hospices are expected to increase by 0.2 percent.

Table 29 also shows the effects of the proposed changes in this rule by the rate of RHC NF/SNF days in quartiles. Column 3 shows that all four quartiles (lowest quartile being less than or equal to 3.1 percent of RHC days in a SNF/NF to the highest quartile being greater than 35.5 percent of RHC days in a SNF/NF) are anticipated to experience a decrease in payments ranging from 0.5 percent for the first quartile to 0.7 percent for the third and fourth quartiles. Column 4 shows the effect of the proposed 50/50 Blend of FY 2016 wage index values under the old and the new CBSA delineations. All four quartiles are anticipated to experience an increase in payments under this proposal with the first and second quartiles anticipated to experience increases of 0.1percent, the third quartile anticipated to experience an increase of 0.3 percent, and the highest quartile to experience an increase in payments of 0.4 percent. Column 5 shows the anticipated impact of the proposed RHC rates on hospices by their rates of RHC days in a SNF/NF. The first and second quartiles are anticipated to see an increase in payments of 0.7 percent and 0.4 percent respectively. The third and fourth quartiles are anticipated to see decreases of 0.1 percent and 0.6 percent respectively due to the proposed RHC rates. Column 6 shows the anticipated effect of the proposed FY 2016 SIA payment on hospices by their rates of RHC days in a SNF/NF. The second quartile is anticipated to see an increase in payments of 0.2 percent. The first and third quartile is expected to experience no change in payments under the FY 2016 SIA payment proposal and the highest quartile is anticipated to experience a decrease in FY 2016 payments of 0.2 percent under this proposal.

f. Effects on Other Providers

This proposed rule would only affect Medicare hospices, and therefore has no effect on other provider types.

g. Effects on the Medicare and Medicaid Programs

This proposed rule only affects Medicare hospices, and therefore has no effect on Medicaid programs. As described previously, estimated Medicare payments to hospices in FY 2016 are anticipated to increase by 1.3 percent, or $200 million.

h. Alternatives Considered

For the FY 2016 proposed rule, we considered several alternatives to the proposals articulated in section III.B. As described in Table 13 in section III.B.1 of this preamble, previous work on a tiered payment model indicates that a different RHC payment could begin at day 31. Therefore, we considered proposing that the higher rate of the RHC payment to be the first 30 days of hospice care given the results above and given that MedPAC identified in their 2008 Report to Congress that the 'break-even' point of profitability was found to be about three weeks. However, because our analysis found that 'marginal costs' continued to decline slightly between days 15–30 and days 31–60 (see figure 5 in section III.B.2 of this preamble), we proposed to begin the lower RHC payment rate on day 61. In addition, we proposed to have the ''count of days'' follow the patient (that is, count the days relative to the patient's lifetime length of stay) to mitigate potential high rates of live discharge and readmission due to the proposed RHC payment rates based on the days of care. For hospice patients who are discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice upon hospice election. We also considered a longer (that is, 90 days) window of time between a discharge and a subsequent hospice election as a basis of determining which RHC payment rate would be applied based on the days following the beneficiary. However, we proposed the 60 day time period. We also considered not applying the higher initial RHC rate (1 through 60 days) to beneficiaries in nursing homes.

For the SIA payment, we considered allowing the first two days of a new hospice election with a unique hospice provider to also be eligible for the SIA payment. The reason for not proposing to allow the SIA payment to apply to the first two days of a new hospice election with a unique hospice was outlined in section III.B. In addition, because the SIA payment is required to be implemented in a budget neutral manner in the first year of implementation, per section 1814(i)(6)(D)(ii), allowing the first two days of the hospice election with a unique hospice provider to be eligible for the SIA payment would result in a larger decrease to the RHC rate for all hospice providers. We estimate that the

RHC would need to be reduced by 1.26 percent (rather than the proposed 0.81 percent).

i. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 30 below, we have prepared an accounting statement showing the classification of the expenditures associated with this proposed rule. Table 30 provides our best estimate of the increase in Medicare payments under the hospice benefit as a result of the changes presented in this proposed rule for 3,879 hospices in our impact analysis file constructed using FY 2014 claims as of December 31, 2014.

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

[In $millions]

Category	Transfers
FY 2015 Hospice Wage Index and Payment Rate Update	
Annualized Monetized Transfers.	$200.
From Whom to Whom?	Federal Government to Hospices.

j. Conclusion

In conclusion, the overall effect of this proposed rule is an estimated $200 million increase in Medicare payments to hospices. The $200 million increase in estimated payments for FY 2016 reflects the distributional effects of the 1.8 percent proposed FY 2016 hospice payment update percentage ($290 million increase), the use of updated wage index data and the phase-out of the wage index budget neutrality adjustment factor (−0.7 percent/$120 million decrease) and the proposed implementation of the new OMB CBSA delineations for FY 2016 hospice wage index with a one-year transition (0.2 percent/$30 million increase). The proposed SIA payment does not result in aggregate changes to estimate hospice payments for FY 2016 as this proposal would be implemented in a budget neutral manner through an overall reduction to the RHC payment rate for all hospices.

2. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than $7.5 million to $38.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. HHS's practice in interpreting the RFA is to consider effects economically ''significant'' only if they reach a threshold of 3 to 5 percent or more of total revenue or total costs. As noted above, the combined effect of the updated wage data and the BNAF phase-out (−0.7 percent decrease or −$120 million) the proposed implementation of the new OMB CBSA delineations for FY 2016 hospice wage index with a one-year transition (0.2 percent increase or $30 million), the proposed SIA payment (no estimated aggregate impact on payments), and the proposed FY 2016 hospice payment update percentage (1.8 percent increase or $290 million) results in an overall increase in estimated hospice payments of 1.3 percent, or $200 million, for FY 2016. Therefore, the Secretary has determined that this proposed rule will not create a significant economic impact on a substantial number of small entities.

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

3. Unfunded Mandates Reform Act Analysis

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

VI. Federalism Analysis and Regulations Text

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

List of Subjects in 42 CFR Part 418

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

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

PART 418—HOSPICE CARE

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

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

Subpart G—Payment for Hospice Care

■ 2. Section 418.302 is amended by—
■ a. Adding paragraphs (b)(1)(i) and (ii).
■ b. Amending paragraphs (d)(1), (d)(2), (e) introductory text, (f)(2) and (f)(5)(ii) by removing the word ''intermediary'' and adding in its place the words ''Medicare Administrative Contractor''.
■ c. Revising paragraph (e)(1).

The revisions and additions read as follows:

§ 418.302 Payment procedures for hospice care.

* * * * *

(b) * * *

(1) * * *

(i) *Service intensity add-on.* Except as provided in paragraph (b)(1)(ii) of this section, routine home care days that occur during the last 7 days of a hospice election ending with a patient discharged as ''expired'' are eligible for a service intensity add-on payment. Such payment must be equal to the continuous home care hourly payment rate, as described in paragraph (e)(4) of this section, multiplied by the amount of direct patient care provided by a RN and/or social worker, up to 4 hours total per day.

(ii) Routine home care days provided to patients residing in a skilled nursing facility (SNF) or a long-term care

nursing facility (NF) are not eligible for the service intensity add-on payment.

* * * * *

(e) * * *

(1) Payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day (except as set out in paragraph (b)(1)(i) of this section).

* * * * *

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

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

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

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

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

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

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

* * * * *

§ 418.308 [Amended]

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

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

§ 418.309 Hospice aggregate cap.

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

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

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

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

* * * * *

Dated: April 23, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: April 27, 2015.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

[FR Doc. 2015–10422 Filed 4–30–15; 4:15 pm]

BILLING CODE 4120–01–P