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

[CMS-1714-F]

Summary of Final Rule

TABLE OF CONTENTS

I. Introduction and Background

On August 6, 2019, the Centers for Medicare & Medicaid Services (CMS) published a final rule updating the Medicare hospice payment rates, wage index, and the quality reporting requirements for fiscal year (FY) 2020 (84 Federal Register 38484).

This rule, required by statute, finalizes annual updates to the hospice wage index, payment rates, and cap amount for FY 2020. This rule also finalizes several proposals for FY 2020. First, this rule rebases the continuous home care (CHC), general inpatient care (GIP), and inpatient respite care (IRC) per diem rates in a budget neutral manner. Second, this rule makes changes to the hospice wage index to remove the 1-year lag in data by using the current year's hospital wage data to establish the hospice wage index. Third, this rule modifies the hospice election statement to require an addendum aimed at increasing transparency for patients under a hospice election. Finally, this rule makes changes to the Hospice Quality Reporting Program (HQRP).

CMS estimates that the overall impact of the final rule will be an increase of $520 million (2.6 percent) in Medicare payments to hospices during FY 2020.

Wage index addenda for FY 2020 (October 1, 2019 through September 30, 2020) are available only through the internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html

The proposed rule reviews the history of the Medicare hospice benefit, including hospice reform policies finalized in the FY 2016 hospice final rule (80 FR 47142); this rule, among other things, differentiated payments for routine home care (RHC) based on the beneficiary's length of stay and implemented a service intensity add-on (SIA) payment for services provided in the last 7 days of a beneficiary's life.

CMS also examines trends in Medicare hospice utilization. CMS notes that the number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to over 1.5 million in FY 2018. Similarly, Medicare hospice expenditures have risen from $2.8 billion in FY 2000 to an estimated $18.7 billion in FY 2018. CMS ongoing analyses continue to show that that there has been a significant increase in the reporting of neurological-based diagnoses, including Alzheimer's disease since 2014 as the principal diagnosis on hospice claims.

CMS also reports on the hospice length of stay or the number of days that a hospice beneficiary receives care under a hospice election. The hospice length of stay is variable and depends on a multitude of factors including disease course, timing of referral, decision to resume curative treatment, and/or stabilization or improvement where the individual is no longer certified as terminally ill. Among the four levels of hospice care, RHC accounts for almost 98 percent of all hospice days.

II. Provisions of the Final Rule

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

CMS notes that there has been little change in the hospice payment structure since the benefit's inception. While the establishment of the payment rates have been updated to account for inflation, it has not implemented any large-scale changes to reflect non-inflationary changes with the exception of the bifurcation of the RHC payment rate and the creation of the SIA payment (2016 final rule). CMS has continued to examine whether additional changes are needed to more accurately align hospice payment with the costs of providing care with particular emphasis on the alignment of payment and costs for CHC, IRC, and GIP. MedPAC in its March 2018 Report to Congress found that Medicare's payment rates for the CHC, IRC and GIP levels of care appear to be lower than average median costs per day for freestanding providers and suggested that rebalancing the payment rates may be warranted.[1]

CMS conducts its own analyses for the proposed rule and updates the analysis for the final rule using data from its revised hospice cost report to estimate hospices' average costs per day by level of care. CMS uses hospice cost reports from FY 2017 in its Healthcare Cost Report Information System (HCRIS), which contains cost and statistical data for freestanding and provider-based hospice providers. It discusses in detail its methodology and analyses of costs per

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

day for CHC, IRC, and GIP. In brief, CMS made several key edits that ultimately resulted in a small sample size of provider-based hospices remaining, such as eliminating SNF, HHA, and hospital cost reports that did not contain a hospice CMS Certification Number (CCN). In addition, CMS also applied industry-requested edits, referred to as "Level I" edits that required hospices to fill out certain parts of their cost reports. CMS made the decision to only use freestanding hospice cost reports to calculate average costs per day for each level of care. After applying the Level I edits and other edits, 1,232 freestanding cost reports remained (after starting with 3,223), though not all costs reports contain information on each level of care.

Using the freestanding cost reports, CMS calculates FY 2019 average costs per day for each level of care. Its approach includes removing any regional differences in the labor share of the base payment rate that may be driven by wages and inflating the average costs in FY 2017 to FY 2019 dollars.

Table 6 in the final rule (reproduced below) shows that the payment rates for CHC, IRC, and GIP are significantly less than the average costs of providing care. For example, the estimated percentage increase in payment rate needed to align costs for the CHC level of care in FY 2019 is 36.6 percent, which would have raised the per diem payment rate from $997.38 to $1,363.26.

Table 6: Comparison of FY 2019 Average Costs to Payments for CHC, IRC and GIP				
Level of Care	**Percent of Days by Level of Care in FY 2018***	**Estimated FY 2019 Average Costs per day**	**FY 2019 Per Diem Payment Rates**	**Estimated Percent Payment Increase Needed to Align with Costs**
CHC	0.2%	$1,363.26/$56.80 (per hour)	$997.38/$41.56 (per hour)	+36.6%
IRC	0.3%	$459.75	$176.01	+161.2%
GIP	1.3%	$992.99	$758.07	+31.0%

Table 7 in the final rule (reproduced below) compares the FY 2019 average costs to payment for RHC. This illustrates that for RHC, the payment rates significantly exceeded the average costs of providing care for the level of care for the first 60 days and any RHC days after day 60.

Table 7: Comparison of FY 2019 Average Costs to Payment for RHC			
Level of Care	**Estimated FY 2019 Average Costs per Day**	**FY 2019 Payment Rates**	**Percent Difference Between Payment and Costs**
RHC Days 1-60	$160.80	$196.25	+18.1%
RHC Days 61+	$124.43	$154.21	+19.3%

Using its hospice payment reform authority under section 1814(i)(6) of the Act, CMS finalizes as proposed to rebase the payment rates for CHC, IRC, and GIP by setting these payment amounts equal to the FY 2019 estimated average costs per day (as described above), and before

application of the hospice payment update percentage. CMS notes that although there is no coinsurance amount for RHC, CHC or GIP, the amount of coinsurance for each respite care day is equal to 5 percent of the payment made by Medicare for a respite care day. Thus, CMS set the rebased IRC payment rate equal to the average per-diem cost of IRC divided by 1.05. Table 8 (reproduced here) shows the final rebased payment rates for CHC, IRC, and GIP.

Table 8: Rebased Payment Rates for CHC, IRC, and GIP*	
Level of Care	**Rebased Payment Rates***
Continuous Home Care (CHC)	$56.80 per hour/$1,363.26 (per day)**
Inpatient Respite Care (IRC)	$437.86***
General Inpatient Care (GIP)	$992.99

*Prior to application of the hospice payment update percentage of 2.6 percent.
** Based on a full CHC per day payment (which covers 24 hours.)
***IRC payment rate accounts for 5 percent coinsurance ($459.75/1.05 = $437.86).

As required by statute,[2] CMS notes that any revisions to the methodology for determining the payment rates for other services included in hospice care be done in a budget-neutral manner in the fiscal year in which the revisions in payment are implemented. CMS finalizes a reduction to the RHC payment rates of 2.72 percent in order to implement rebasing in a budget-neutral manner in FY 2020. This percentage decrease in RHC payment rates would offset the proposed increases in payment rates to the CHC, IRC, and GIP levels of care. The finalized 2.72 percent reduction will be applied to the RHC payment rates for the first 60 days and the RHC days after day 60.

CMS believes that the rebased rates more closely align costs with payment and that the new rates for CHC, IRC, and GIP may help appropriately increase access to these levels of care. Likewise, CMS believes the rebased rates are responsive to industry concerns regarding the challenges in securing needed contracts with facilities to provide inpatient levels of hospice care.

Commenters raised concerns that the reduced RHC rates would impede access to hospice care, that the higher IRC and GIP rates would be passed along to contractors and so hospices would only experience the reduction in RHC rates, and that the higher IRC rates would increase incentives for over-use of inpatient services. CMS responds that the reductions overall are small relative to hospice margins and that existing rules regarding utilization of hospice services will help to prevent incentives to over-use inpatient care. In addition, CMS believes that some of the shift in incentives is warranted. Finally, CMS states that it will continue to closely analyze any changes in patterns of care in response to these changes. In response to those commenters who question CMS' reliance on cost reports for this analysis because they are incomplete and inaccurate, CMS states that those reports are required to be certified to be true and accurate,

[2] Section 1814(i)(6)(D)(ii)

prepared from the books and records of the hospice administrator, and signed by the Chief Financial Officer so the expectation is that the data are true and accurate.

B. FY 2020 Hospice Wage Index and Rates Update

A summary of key data for the final hospice payment rates for FY 2020 is presented below with additional details in the subsequent sections.

Summary of Key Data for Hospice Payment Rates for FY 2020			
Market basket update factor			
Market basket increase			+3.0%
Required multi-factor productivity (MFP) adjustment			-0.4%
Net MFP-adjusted update reporting quality data			**+2.6%**
Net MFP-adjusted update not reporting quality data			**+0.6%**
Hospice aggregate cap amount			$29,964.78
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2019 Federal Rates Per Diem**	**Final FY 2020 Federal Rates Per Diem**
Routine Home Care (days 1-60)	68.71%	$196.25	$194.50
Routine Home Care (days 61+)	68.71%	$154.21	$153.72
Continuous Home Care, Full Rate = 24 hours of care, $58.15 hourly rate	68.71%	$997.38	$1,395.63
Inpatient Respite Care	54.13%	$176.01	$450.10
General Inpatient Care	64.01%	$758.07	$1,021.25
Service Intensity Add-on (SIA) payment, up to 4 hours			$58.18 per hour

Note: FY 2020 rates for CHC, IRC, and GIP reflect the finalized proposal to rebase payment rates. RHC rates for FY 2020 are virtually the same as in FY 2019 as the 2.72 percent budget neutrality adjustment offsets the 2.6 percent hospice payment update percentage. RHC days accounted for 98.2 percent of all hospice days in FY 2018.

1. FY 2020 Hospice Wage Index

For FY 2020, CMS finalizes its proposal to change from the established policy of using the pre-floor, pre-reclassified acute care hospital wage index from the prior fiscal year as the basis for the hospice wage index, and instead to align with the same timeframe used by the IPPS and other payment systems. For 2020, CMS will use the pre-floor, pre-reclassified hospital wage index from the current fiscal year as the basis for the hospice wage index. Thus, the FY 2020 hospice wage index is based on the FY 2020 pre-floor, pre-reclassified IPPS hospital wage index rather than on the FY 2019 pre-floor, pre-reclassified IPPS hospital wage index.

CMS will continue to apply current policies for handling geographic areas where there are no hospitals. For urban areas of this kind, all of the core-based statistical areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value for use as a reasonable proxy for these areas. For FY 2020, there is only one CBSAs without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. (When the proposed rule was issued, a second CBSA, 16180, Carson City, NV, was

also without a source of wage data, but by the time the final rule was issued, wage data became available.) The FY 2020 wage index value for Carson City, NV is 1.0070 and the wage index value for Hinesville-Fort Stewart, Georgia is 0.8322.

For rural areas without hospital wage data, CMS has used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. However, the only rural area currently without a hospital is on the island of Puerto Rico, which does not lend itself to this "contiguous" approach. Because CMS has not identified an alternative methodology, the agency will continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

CMS notes that it identified a programming error in the calculations of the wage index values as described in the proposed rule. CMS has corrected those errors and the corrected amounts are reflected in the final hospice wage index for 2020 which are available at https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/Hospice/Hospice-Wage-Index.html. The hospice wage index for FY 2020 will be effective October 1, 2019 through September 30, 2020.

2. Hospice Payment Update Percentage

For FY 2020, the inpatient hospital market basket update of 3.0 percent (the inpatient hospital market basket is used in determining the hospice update factor) must be reduced by a productivity adjustment as mandated by the ACA (currently estimated to be 0.4 percentage point). This results in a final hospice payment update percentage for FY 2020 of 2.6 percent.

CMS notes that the labor portion of the hospice payment rates is currently as follows: for Routine Home Care, 68.71 percent; for Continuous Home Care, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent. CMS also states that it continues to analyze hospice cost report data for possible use in updating the labor portion of the hospice payment rates, and that any changes would be proposed in future rulemaking and be subject to public comments.

3. FY 2020 Rebased Hospice Payment Rates

In the hospice payment system, there are four payment categories that are distinguished by the location and intensity of the services provided: RHC or routine home care, IRC or short-term care to allow the usual caregiver to rest, CHC or care provided in a period of patient crisis to maintain the patient at home, and GIP or general inpatient care to treat symptoms that cannot be managed in another setting. The applicable base payment is then 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.[3]

In FY 2016 Hospice final rule, CMS made several modifications to the hospice payment methodology. CMS implemented two different RHC payment rates: one for the RHC rate for

[3] In FY 2014 and for subsequent fiscal years, CMS uses rulemaking as the means to update payment rates (prior to FY 2014, CMS had used a separate administrative instruction), consistent with the rate update process for other Medicare payment systems.

the first 60 days and a second RHC rate for days 61 and beyond. CMS also adopted a Service Intensity Add-on (SIA) payment when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provider (up to 4 hours total) that occurred on the day of the service. As required by statute, the new RHC rates were adjusted by a SIA budget neutrality factor. For FY 2020, the budget neutrality factor for days 1 through 60 is 0.9924, and for days 61 and beyond the factor is 0.9982.[4]

In the FY 2017 Hospice final rule, CMS initiated a policy to apply a wage index standardization factor to hospice payment rates in order to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data. CMS uses the same approach in other payment settings such as under Home Health Prospective Payment System (PPS), IRF PPS, and SNF PPS. To calculate the wage index standardization factor, CMS simulated total payments using the FY 2020 hospice wage index and compared it to its simulation of total payments using the FY 2019 hospice wage index. By dividing payments for each level of care using the FY 2020 wage index by payments for each level of care using the FY 2019 wage index, CMS obtained a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP). These factors are shown in the tables below.

Tables 10 and 11 of the final rule (reproduced below) lists the final FY 2020 hospice payment rates by care category as well as the final SIA budget neutrality factors and the final wage index standardization factors. These tables take into account CMS' finalized proposal to rebase the per diem payment rates for the CHC, IRC, and GIP levels of care, and the reduction of RHC rates by 2.72 percent to maintain budget neutrality.

Table 10: FY 2020 Hospice RHC Payment Rates

Code	Description	Proposed FY 2019 Budget Neutral RHC Payment Rates	SIA budget neutrality factor adjustment	Wage Index Standardization Factor	Proposed FY 2020 Hospice Payment Update	Proposed FY 2020 Payment Rates
651	Routine Home Care (days 1-60)	$190.91	x 0.9924	x 1.0006	x 1.026	$194.50
651	Routine Home Care (days 61+)	$150.02	x 0.9982	x 1.0005	x 1.026	$153.72

[4] The budget neutrality adjustment calculation 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. Similarly, the budget neutrality adjustment for 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.

Table 11: FY 2020 CHC, IRC, and GIP Payment Rates					
Code	**Description**	**Proposed FY 2019 Payment Rates**	**Wage Index Standardization Factor**	**Proposed FY 2020 Hospice Payment Update**	**Proposed FY 2020 Payment Rates**
652	Continuous Home Care Full Rate = 24 hours of care	$1,363.26 ($56.80/hourly rate)	x .9978	x 1.026	$1,395.63 ($58.15/hourly rate)
655	Inpatient Respite Care	$437.86	x 1.0019	x 1.026	$450.10
656	General Inpatient Care	$992.99	x 1.0024	x 1.026	$1,021.25

Tables 12 and 13 of the final rule (84 FR 38504-38505) list the comparable FY 2020 payment rates for hospices that do not submit the required quality data under the Hospice Quality Reporting Program as follows: Routine Home Care (days 1-60), $190.71; Routine Home Care (days 61+), $150.72; Continuous Home Care, $1,368.42; Inpatient Respite Care, $441.32; and General Inpatient Care, $1,001.35.

4. Hospice Cap Amount for FY 2020

By way of background, when the Medicare hospice benefit was implemented, Congress included two limits on payments to hospices: an aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end-of-life, and the intent of the inpatient cap was to ensure that hospice remained a home-based benefit.[5] The aggregate cap amount was set at $6,500 per beneficiary when first enacted in 1983, and since then this amount has been adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI-U).

As required by the Impact Act, beginning with the 2016 cap year, the cap amount for the previous year will be updated by the hospice payment update percentage, rather than by the CPI-U for medical care. This provision will sunset for cap years ending after September 30, 2025, and revert back to the original methodology. CMS adds that the final hospice aggregate cap amount for the 2020 cap year will be $29,964.78 per beneficiary or the 2019 cap amount updated by the FY 2020 hospice payment update percentage ($29,205.44 * 1.026).

[5] 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.

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

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

To be eligible to elect the Medicare hospice benefit, a beneficiary must be certified as terminally ill, defined as having a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course (42 CFR 418.3). The initial hospice certification requires both the patient's designated attending physician (if any) and the hospice medical director (or the hospice physician member of the interdisciplinary group (IDG)) to certify in writing, at the beginning of the period, that the individual is terminally ill based on their clinical judgment regarding the normal course of the individual's illness. The hospice medical director must consider the principal diagnosis of the patient, all other health conditions, whether related or unrelated to the terminal condition, and all clinically relevant information supporting all diagnoses. In addition, for the initial certification of terminal illness, the hospice Conditions of Participation (CoPs) at §418.102(b) require that the hospice medical director or hospice physician designee consider not only the principal diagnosis and related conditions, but also current signs and symptoms affecting the patient, current medications and treatment interventions, and the medical management of unrelated conditions.

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

During the initial assessment, the hospice must provide the patient or representative with both spoken and written notice of the patient's rights and responsibilities (§418.52). The beneficiary has the right to be involved in the development of the care plan; receive information about the services covered under the hospice benefit; and receive information about the scope of services that the hospice will provide and specific limitations on those services. In addition, beneficiaries must be informed that the care for which Medicare payment is sought will be subject to the Quality Improvement Organization (QIO) review, including the role of the Medicare Beneficiary and Family-Centered Care-QIO (BFCC-QIO) in reviewing quality of care concerns and appeals.

Hospice CoPs require that the hospice registered nurse (RN) must complete the initial assessment within 48 hours after the election of hospice care, unless it is requested to be completed sooner (§418.54). The hospice IDG, in consultation with the attending physician, must complete a comprehensive assessment no later than 5 days after election of hospice care. The comprehensive assessment includes assessing the patient for complications and risk factors, and the plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions (§418.56(c)). The hospice interpretative guidelines for §418.56 state that the plan of care should also identify the conditions or symptoms that the

hospice determines to be "unrelated" so hospices can provide ongoing sharing of information with other non-hospice providers who may be furnishing services unrelated to the terminal illness and related conditions. In the 2008 Hospice CoPs final rule (73 FR 32088), CMS stressed the need to show a direct link between the needs identified in the comprehensive assessment and the plan of care. Thus, if the hospice identified other needs in the patient assessment that were unrelated to the terminal illness and related conditions, these needs could not be ignored, and the hospice would have to communicate and coordinate with the non-hospice providers responsible for these conditions (73 FR 32114). Hospices are required to have a communication system with other non-hospice health care providers. In addition, hospices are required to designate a RN, a member of the IDG, to coordinate implementation of the comprehensive care plan including communication with other health care providers.

2. Service Unrelated to the Terminal Illness and Related Conditions

During a hospice election, Medicare coverage of services received outside of the Medicare hospice benefit is determined by whether or not the services are for the treatment of a condition unrelated to the individual's terminal illness and related conditions. CMS states it is longstanding policy that services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare given the comprehensive nature of the hospice benefit (48 FR 56008-56010). Edits within the claims processing system prevent other non-hospice claims from being processed without the use of a modifier or condition code indicating that the service billed is unrelated to the patient's terminal condition.

CMS discusses numerous concerns related to care coordination and the provision of care provided by non-hospice providers. A OIG report identified situations where Medicare may have paid twice for prescription drugs for hospice beneficiaries and beneficiaries may have paid unnecessary co-payments or coinsurance for prescription drugs.[6] The OIG identified four common categories of drugs being covered under Part D for beneficiaries under a hospice election that are typically used to treat end-of-life symptoms: analgesics, anti-nauseants, laxatives, and antianxiety agents. In response to this report, CMS issued several memoranda clarifying the criteria for determining payment responsibility under the Part A hospice benefit and Part D drugs prescribed to hospice beneficiaries. In 2014, beneficiary-level prior authorization (PA) was instituted for all beneficiaries in hospice and Part D utilization decreased. CMS reports that analyses of Part D prescription drug event (PDE) data suggest that the current PA process has reduced Part D program payments for the four targeted drug categories and that utilization patterns are sensitive to the PA process.[7] CMS notes that after a hospice election, many maintenance drugs used to treat or cure a condition are typically discontinued but there are maintenance drugs that are appropriate to continue as they may offer symptomatic relief for the palliation and management of terminal illness and related conditions (e.g. maintenance drugs for heart disease and diabetes).

CMS also discusses concerns related to non-hospice expenditures related to DME and supplies. CMS' analysis showed that items such as oxygen, respiratory agents, hospital beds, and

[6] OIG, HHS. Medicare Could be Paying Twice for Prescription Drugs for Beneficiaries in Hospice. June 2012. A-06010-00059. https://oig.hhs.gov/oas/reports/region6/61000059.pdf.
[7] https://www.cms.gov/Medicare.Medicare-Fee-for-Service-Paymnet/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf.

wheelchairs were not being furnished or covered by the hospice even though CMS expected such items to be clinically indicated and provided for the palliation and management of the terminal illness and related conditions. In addition, CMS notes the numerous reports from beneficiaries, families, and non-hospice providers, including examples from recent Medicare Ombudsman reports, that hospice patients have been told that hospice would not cover a drug or service because the hospice determined they were unrelated to the terminal illness and related conditions and this notification was not timely.

CMS acknowledges that since the implementation of the hospice benefit, it has received frequent requests to provide guidance about what are considered "related conditions" and included in the hospice benefit. CMS reiterates that any service needed outside of the hospice benefit (that is, "unrelated") should be exceptional and rare. CMS cites the numerous guidance it has provided and remains concern that decisions about "related" and "unrelated" conditions are based on a narrow view of the overall condition of the individual. CMS is also concerned about the extent that patients are being adequately informed about the scope of services covered under the Medicare hospice benefit and whether patient rights are being fully promoted and protected.

3. Proposed Election Statement Content Modifications and Proposed Addendum to Provide Greater Coverage Transparency and Safeguard Patient Rights

Hospice Election Statement. In addition to the existing statement content requirements at §418.24(b) CMS proposed that hospices also be required to include the following on the election statement:

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

CMS finalizes those requirements with two modifications in response to commenters' concerns – one to the timing for providing the election statement addendum; and a second, to delay for one year the effective date for these new requirements overall. Under the final rule, hospices will be required to comply with these provisions beginning in FY 2021 and the election addendum will be required to be provided, for those beneficiaries requesting it at the time of hospice election, within 5 days of the start of hospice care instead of within 48 hours.

Election Statement Addendum. CMS finalizes that hospices will be required, upon request, to provide to the beneficiary (or representative) an election statement addendum with a list and rationale for the conditions, items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. Hospices will also be required to provide

the election statement addendum upon request to other non-hospice providers that are treating such conditions, and Medicare contractors who request such information.

If the election statement addendum is requested at the time of hospice election, the hospice must provide this information, in writing within 5 days of the start of hospice care (instead of 48 hours as proposed). In extending the timeline for the addendum, CMS agreed with commenters who pointed out that some of the information needed for the addendum may not be known prior to the completion of the comprehensive assessment which must be provided within 5 days. The final rule conforms those timelines.

Hospices are exempt from completing this addendum if the beneficiary dies within 5 days of the election date of hospice care. If the addendum is requested during the course of hospice care, the hospice must provide this information, in writing, immediately to the requesting beneficiary (or representative), non-hospice provider, or Medicare contractor. CMS believes this information should be readily available in the beneficiary's hospice medical record. If there are changes to the hospice plan of care that determine a new illness or condition has arisen, hospices are required to issue an updated addendum to the patient (or representative) reflecting whether or not items, services, and supplies related to the new illness or condition will be provided by the hospice. This applies for both additions and removal of any unrelated conditions, items, services, and/or drugs.

Hospices can develop and design the addendum, similar to how they develop their own hospice election statement. CMS plans to develop a model addendum. CMS also intends to work with hospices and Part D plans to develop a process in which the "Patient Notification of Hospice Non-covered Items, Services and Drugs' could be used at the point -of-service when hospice beneficiaries are filling drug prescriptions.

The addendum called the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" is required to include the following information: finalized at §418.24:

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

- *Purpose of Addendum*. (i). The purpose of the addendum is to notify the beneficiary (or representative) of those conditions, items, services, and drugs the hospice will not cover because the hospice has determined they are unrelated to the beneficiary's terminal illness and related conditions. (ii). The addendum is subject to review and shall be updated, as needed, when the plan of care is updated in accordance with §418.56. The hospice will provide these updates in writing to the beneficiary (or representative).
- *Right to Immediate Advocacy*. The addendum must include language that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice's determination. The language must include contact information for the BFCC-QIO and required language that encourages the beneficiary to contact the hospice provider to discuss the information on the form. In addition, required language will provide information about the BFCC-QIO and the ways the BFCC-QIO can assist you.

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

CMS finalizes that the signed addendum and updates become a new condition for payment. The addendum will not be required to be submitted with any hospice claims. Separate consent will not be needed to release this information to non-hospice providers furnishing services for unrelated condition (45 CFR 164.506). CMS notes that the CoPs already require that this information should be documented and communicated to beneficiaries but that making this a condition for payment will help ensure this information is provided.

The election statement addendum is only required for beneficiaries who request this information; hospices may choose to provide this information to all patients, regardless of payer source. Hospices can determine which member of the IDG is responsible for completing the addendum; CMS expects this typically would be the hospice RN responsible for the plan of care.

CMS believes that the election statement addendum will provide greater transparency about coverage under the Medicare hospice benefit, inform the beneficiary about services they might need to obtain outside the hospice benefit, and allow a beneficiary to anticipate potential financial liabilities. CMS notes this addendum is not to be used for hospices to exercise unlimited ability to determine services as unrelated to the terminal illness and related conditions.

CMS received many comments, some supporting the notice and addendum and others voicing concerns about the proposal including operational concerns, concerns with the proposed timelines, opposition to including the addendum as a condition of payment, and specific concerns with the items proposed to be included in the notice or addendum. Other commenters recommended that CMS better define services that are related to the terminal condition for which an individual is admitted versus unrelated services. Some recommended alternative existing forms that could be used for this purpose or that already include sufficient information for beneficiaries. Some commenters requested CMS conduct more analyses to determine whether the issue of non-hospice expenditures is significant.

In response to comments, CMS points out that the delay in applicability of the requirements for a full year will permit CMS to consider more carefully some of the operational, logistical, and educational concerns raised. CMS notes that it has been analyzing payments for non-hospice expenditures for years and cites prior proposed and final rules in which these analyses have been described.[8] With respect to defining related and unrelated services, CMS recalls that, in past comment letters, commenters have overwhelmingly opposed CMS issuing definitions of related and unrelated services. Instead most commenters assert that hospices are expert at making such clinical determinations.

Finally, CMS reminds stakeholders about the informal alternative dispute resolution process that may be used to quickly resolve a Medicare beneficiary's (or his or her representative's) verbal complaint regarding the quality of Medicare-covered health care received or accompanying services (Immediate Advocacy with the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC–QIO)).

Collection of Information Requirements.

Because the hospice regulations and CoPs already require the assessment and documentation of unrelated conditions, CMS believes the collection of information for the election statement and the addendum is already accounted for in the hospice CoP burden estimates in the information collection request that was re-approved in November 2017 (OMB control number:0938-1067). CMS also believes there is no increase in hospice burden from this addendum requirement to communicate with non-hospice providers.

CMS estimates a one-time hospice cost burden to develop the addendum and a small increase in the time spent to complete the addendum. The estimated total per hospice and total annual hospice costs associated with the proposed addendum are shown in Table 20 (reproduced below) The burden estimate assumes that an itemized list would be requested by every beneficiary receiving non-hospice services, or by the non-hospice providers rendering these unrelated services. CMS notes, however, that the actual burden would be less as hospices are already required to be comprehensive in their approach to covered services and some hospices would not have to complete the addendum because they provide all items, services, and drugs.

Table 20: FY 2020 Estimated Per Hospice and Total Hospice Costs for Election Statement Addendum

	Average # Of Elections Per Hospice	Total # of Hospice Elections (based on FY 2017)
# of Hospice Elections	205	913,318
	Average Cost Per Hospice	Total Annual Costs for All Hospices
Total # of Hospices		4,465
One-time Form Development	$44.58	$199,050
RN Form Completion	$2,481	$11,077,665
Total Hospice Estimated FY2020 Costs		$11,276,715

[8] Including in the FY 2016 hospice wage index proposed rule (80 FR 25849) and FY 2019 hospice wage index proposed rule (83 FR 20946.)

CMS believes the addendum will streamline existing regulatory requirements into a single tool for communication with beneficiary's and non-hospice providers. In addition, CMS discusses numerous other benefits from the addendum including the potential that the addendum may provide the necessary documentation to support the services provided by the non-hospice provider and allow the non-hospice provider to be "without fault' if there is any question regarding an overpayment.

CMS calculated the average number of hospice beneficiaries per non-hospice provider by analyzing all Medicare Parts A and B non-hospice claims for beneficiaries under a hospice election period in FY 2017. CMS also examined the Part D claims for drugs provided to hospice beneficiaries under a hospice election. CMS notes that because it double-counted beneficiaries, it expects that the average to be larger than the ratio of unique beneficiaries to unique non-hospice providers. Based on FY 2017 data, CMS found the average number of hospice beneficiaries per institutional claims submitted with condition code 07 was 11, the average number of hospice beneficiaries per non-institutional lines submitted with the "GW" modifier was 12, and the average number of hospice beneficiaries per Part D claims was 12 (see Table 22 for more details).

To estimate the cost burden reduction, CMS calculated the estimated current burden for communicating and coordinating information regarding unrelated conditions between hospice and non-hospice providers. CMS believes that this estimated burden would be reduced because it will take less time for non-hospice providers to contact and obtain the necessary information. The estimated total overall burden reduction for non-hospice providers using the proposed addendum are shown in Table 22 (reproduced below).

Table 22: FY 2020 Estimated Total Overall Burden Reduction for Non-Hospice Providers Using Election Statement Addendum

Non-Hospice Claims	Burden without Addendum	Burden with Addendum	Estimated Burden Reduction for Non-Hospice Providers
Institutional Claims with Condition Code 07	$3,838,471	$1,279,490	$2,558,981
Non-Institutional Claims with GW Modifier	$14,960,373	$4,986,791	$9,973,581
Part D Maintenance Drugs	$5,951,637	$1,979,028	$3,972,609
Total Burden Reduction for Non-Hospice Providers	**$24,750,481**	**$8,245,309**	**$16,505,172**

For FY 2020, CMS estimates the use of the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs' election statement addendum would result in a total overall burden

reduction of -$5,228,457 (estimated costs for the election statement addendum (+$11,276,715) - estimated burden reduction for non-hospice provider using the election statement addendum -$16,505,172)).

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

The Medicare hospice benefit is only available as part of fee-for-service (FFS) Medicare and is excluded from the scope of what Medicare Advantage (MA) plans must offer (section 1852(a)(1)(B)(i) of the Act. MA enrollees that elect the hospice benefit remain in their MA plan but receive hospice care through FFS Medicare. CMS pays hospices directly for these services and pays the MA plan the rebate amount, but not the risk-adjusted capitated amount for Part A and Part B services, The MA plan remains responsible for the provision of supplemental benefits and a MA-PD is responsible for Part D drugs that the hospice has determined are unrelated to the enrollee's terminal illness and related conditions. The costs for any items, services, or non-Part D drugs that the hospice has determined to be unrelated to the beneficiary's terminal illness and related conditions are Medicare FFS costs and not MA plan costs (§§422.320(c)(3) and 417.585. Beginning in 2021, under the CMS Innovation Center's authority (section 1115A of the Act), a voluntary model will allow MA enrollees in participating plans to have hospice care provided through their MA plan.

CMS believes that incorporating hospice into other kinds of care delivery models may be another way to alleviate payment fragmentation. CMS sought information about the following:

- The interaction of the hospice benefit and various alternative care delivery models (including MA and Accountable Care Organizations (ACOs)), and other future models designed to change the incentives in providing care under traditional FFS Medicare.
- Information on the impact of alternative delivery and payment models implemented outside of the Medicare program on the provision of hospice care and any lessons learned that should be considered for the future design of the hospice benefit.
- Operational considerations that would need to be addressed to incorporate the hospice benefit into MA, ACOs or other models. For example, for MA, unless an alternative approach to building hospice into the current bid for Part A and B services were followed, county benchmarks and the risk adjustment model would need to be revised to incorporate the costs of these beneficiaries.
- How hospice care is related to other treatment options, including how it impacts the provision of a spectrum of care for those that need supportive and palliative care both before becoming hospice eligible and after hospice care.
- Any care coordination differences for hospice patients that prior to hospice election received care through FFS, were enrolled in an MA plan, or received care from providers participating in an ACO.
- The pros and cons of including hospice services as part of the benefits provided in value-based or capitated payment arrangements.

CMS does not generally summarize or respond to comments in the final rule for RFIs but will take the comments it received in response to this RFI into account in the development of potential future regulations. CMS notes that those comments will help inform future payment

models, the role of hospice with respect to ACO models, and CMS' general understanding of the impact of the increasing penetration of MA.

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

The Hospice Quality Reporting Program (HQRP) includes the Hospice Item Set (HIS) and the Consumer Assessment of Healthcare Providers and System (CAHPS). Section 1814(i)(5)(A)(i) of the Act requires that beginning in FY 2014, hospices that fail to meet quality data submission requirements will receive a two percentage point reduction to the market basket update.

1. Update to Quality Measure Development for Future Years

In the FY 2014 Hospice final rule (78 FR 48256), CMS finalized the HIS as the data collection mechanism for reporting HQRP measures. CMS also finalized that hospice providers are required to provide 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.

The table below provides a summary of measures previously finalized for the FY 2019 and subsequent years annual payment update (APU).

Finalized Quality Measures Affecting the FY 2019 Payment Determination and Subsequent Years		
NQF Number	**Measure Name**	**Year the Measure was Adopted for Use in the Annual Payment Determination (APU)**
1617	Patients Treated with an Opioid Who Are Given a Bowel Regimen	FY 2016
1634	Pain Screening	FY 2016
1637	Pain Assessment	FY 2016
1639	Dyspnea Screening	FY 2016
1638	Dyspnea Treatment	FY 2016
1641	Treatment Preferences	FY 2016
1647	Beliefs/Values Addressed (if desired by the patient)	FY 2016
3225	Hospice and Palliative Care Composite Measure – Comprehensive Assessment at Admission	FY 2019
To Be Determined	Hospice Visits When Death is Imminent	FY 2019

Claims-Based and Outcome Quality Measure Development. CMS did not propose new claim-based or outcome measures but solicited comments and suggestions related to ideas for future-claims based and outcome measure concepts and quality measures. CMS received comments both supporting the use of claims-based measures and some expressing concerns about the limited scope of such measures – that they capture process but not outcomes, are not good indicators of quality, and do not reflect the full scope of hospice experience. CMS will continue to take the comments into consideration in the development of such measures in the future.

*Update on Claims-Based Measure Developmen*t. In the FY 2018 Hospice final rule (82 FR 36638), CMS identified two high-priority areas for claims-based measure development: potentially avoidable hospice care transitions and access to levels of hospice care.

The potentially avoidable hospice care transition concept was developed into the "Transitions from Hospice Care, Followed by Death or Acute Care" measure. The goal of this measure is to identify hospices that have notably higher rates of live discharges followed shortly by death or acute care utilization, when compared to their peers. The measure was reviewed by the Measure Applications Partnership (MAP) in December 2018.[9] The MAP did not support the measure as specified and made several recommendations including reconsidering the exclusion criteria for the measure and shortening the measure timeframe.[10]

CMS has determined that the access to levels of hospice care measure concept could result in hospices providing higher levels of care when it is not required by the plan of care or expected by CMS.

CMS sought comment on ways to further develop these two measure concepts and different measure concepts that are considered high priority areas. In response, commenters generally agreed that the two areas CMS identified reflect high priority areas and that CMS' proposed measures, however, need further modification or testing. Recommendations for changes to the hospice transitions measure include excluding live discharges when a patient elects to transfer or to be discharged and simplifying the measure by splitting it into two different measure concepts. Others raised various limitations of claims data for such measures. CMS states that it will take the comments it received into consideration as it explores options for measuring these concepts.

Update on the Hospice Assessment Tool. In the FY 2018 Hospice final rule (82 FR 36638), CMS discussed plans to develop a hospice assessment tool. CMS would like to replace HIS and capture data with a hospice assessment instrument. A technical expert panel was held in October 2017 and a pilot study with 9 hospice sites began in December 2017. The pilot findings, lessons learned, and goals of a hospice assessment tool were discussed at a September 2018 special open door forum (SODF).[11] At the SODF, a request was made to change the name of the hospice assessment tool from Hospice Evaluation Assessment Reporting Tool (HEART) to a name not confused with other HQRP related tools such as the Hospice Abstraction Reporting Tool (HART).

CMS sought stakeholder feedback on a new name for the hospice assessment tool and received a number of recommendations in response. In this final rule, CMS finalizes a new name for the hospice assessment tool: Hospice Outcomes & Patient Evaluation (HOPE). Other stakeholders generally supported the development of a new assessment tool. CMS notes that it will keep providers informed about future measure and assessment tool development and will solicit

[9] Details about the measure can be found on the NQF website, http://www.quality.forum.org/map.
[10] The MAP recommendations are discussed in the February 15, 2019 final report, https://www.quality.forum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89400.
[11] The transcript for the SODF can be found at https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html.

stakeholder input through regular sub-regulatory channels. Future rulemaking will be used for communicating measure concepts under development and timelines for implementation.

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

Hospices are currently required to submit HIS data to CMS using the Quality Improvement and Evaluation System (QIES) Assessment and the Submission Processing (ASAP) system. In FY 2020, CMS plans to migrate to a new internet Quality Improvement and Evaluation System (iQIES) and designated that system as the data submission system for the Hospice QRP. CMS finalizes its proposal that effective October 1, 2019, it will notify the public of any changes to the CMS-designated system in the future using sub-regulatory mechanisms.

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

The CAHPS® Hospice Survey collects data on the experiences of hospice patients and the primary caregivers listed in the hospice record. The survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver about the patient and family experience of care. The CAHPS® Hospice Survey measures received NQF endorsement in 2016 (NQF #2651). Measures include 6 composite measures and 2 global rating measures. These 8 measures are reported on Hospice Compare. Questions about the CAHPS® Hospice Survey should be sent to the CAHPS® Hospice Survey Team at hospiceCAHPSurvey@HCQIS.org or telephone 1-844-472-4621.

Data Sources. CMS previously finalized that to meet the HQRP requirements for FYs 2020 through 2022 APU determinations, hospices would contract with a CMS-approved vendor to collect survey data for eligible patients on a monthly basis and report that data to CMS on the hospice's behalf by the quarterly deadlines established for each data collection period. The list of approved vendors is available at http://www.hospiceCAHPSsurvey.org.en.approved-vendor-list. Hospices are responsible for making sure their survey vendors meet all the data submission deadlines.

CMS proposed to extend the same participation requirements for FY 2023 and all future years and requested comment on the survey questionnaire. CMS received comments that the survey is too long, complex, and duplicative. Some commenters recommended changes to the timing of data collection and to the exclusions. Other recommendations were to better distinguish, for patient's families, between hospice and nursing home or assisted living facility staff and to take into account hospice characteristics when looking at quality measures. CMS will take the recommendations and comments into consideration as it considers potential changes in future rulemaking.

Public Reporting. CMS has reported the results of the CAHPS® Hospice Survey on Hospice Compare since February 2018. CMS reports the most recent 8 quarters of data on the basis of a rolling average. The data is refreshed 4 times a year in February, May, August, and November.

Volume-based Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. In the FY 2017 final rule (82 FR 36671), CMS finalized that hospices with fewer than 50 survey-eligible decedents/caregivers in the specified reporting period are exempted from the CAHPS® Hospice Survey data collection and reporting requirements for the corresponding payment determination (corresponds to the CY data collection period). To qualify for this exemption, hospices have to submit an annual exemption request form. The exception request form is available on the CAHPS® Hospice Survey web site at htpp://www.hospiceCAHPSurvey.org.

For FY 2022, CMS proposes to provide an automatic exemption to any hospice that is an active agency and according to CMS data sources has served less than a total of 50 unique decedents/caregivers in the reference year. The automatic exemption would be good for 1 year and reassessed annually.

Hospices that have a total count of more than 50 unique decedents/caregivers in the reference year, but have a total of fewer than 50 survey-eligible decedents/caregivers will not be granted an automatic exemption. These hospices may quality for a size exemption but would need to apply for an exemption by submitting the size exemption form. Any exemption granted would be valid for only one year and an exemption request would need to be submitted annually.

The key dates for the volume-based exception for the CAHPS® Hospice Survey are summarized in Table 14 in the final rule (reproduced below).

Table 14: Size Exemption Key Dates for FY 2021 through 2025

Fiscal Year	Data Collection Year	Reference Year (Count total number of unique patients in this year)	Size Exemption Form Submission Deadline
2021	2019	2018	December 31, 2019
2022	2020	2019	December 31, 2020
2023	2021	2020	December 31, 2021
2024	2022	2021	December 31, 2022
2025	2023	2022	December 31, 2023

Newness Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. CMS previously finalized a one-time newness exemption for hospices that meet the criteria (81 FR 52181). Specifically, hospices that are notified about their Medicare CCN after January 1, 2021 are exempted from the FY 2023 APU CAHPS® Hospice Survey requirement due to newness. CMS notes no action is required by the hospice to receive this exemption. The newness exemption is a one-time exemption from the survey. CMS encourages hospices to keep the letter providing them with their CCN.

Survey Participation Requirements. To meet participation requirements for a given year APU, Medicare certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from the corresponding FY reporting period. The table below, reprinted from the FY 2019 Hospice final rule (83 FR 38643) provides the deadlines for data submission for FYs 2023 through 2025. CMS notes there are no late submissions after the deadline, except for extraordinary circumstances beyond the control of the provider.

CAHPS® Hospice Survey Data Submission Dates for the APUs in FYs FY 2023-2025	
Sample Month[1]	**Quarterly Data Submission Deadlines[2]**
FY 2023 APU	
January-March 2021 (Q1)	August 11, 2021
Monthly data collection April-June 2021 (Q2)	November 10, 2021
Monthly data collection July-September 2021 (Q3)	February 9, 2022
Monthly data collection October-December 2021(Q4)	May 11, 2022
FY 2024 APU	
January-March 2022(Q1)	August 10, 2022
Monthly data collection April-June 2022 (Q2)	November 9 2022
Monthly data collection July-September 2022 (Q3)	February 8, 2023
Monthly data collection October-December 2022 (Q4)	May 10, 2023
FY 2025 APU	
January-March 2023 (Q1)	August 9, 2023
Monthly data collection April-June 2023 (Q2)	November 8, 2023
Monthly data collection July-September 2023 (Q3)	February 14, 2024
Monthly data collection October-December 2023(Q4)	May 8, 2024

[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, which are August, November, February, and May.

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

The Hospice Compare Website allows consumers, providers, and other stakeholders to search for all Medicare-certified hospices and view their information and quality measures. The website reports the 7 HIS measures, the CAHPS® Hospice Survey, and the Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission.

Update to Quality Measures to be Displayed on Hospice Compare in FY 2019. In the FY 2017 Hospice Final Rule (81 FR 52163 to 52169), CMS finalized the "Hospice Visits when Death is Imminent" measure pair for implementation April 1, 2017. This measure assesses whether the needs of hospice patients and their caregivers were addressed by the hospice staff during the last days of life. Measure 1 assesses the percentage of patients receiving at least 1 visit from a RN, physician, nurse practitioner or physician assistant in the last 3 days of life. Measure 2 assesses the percentage of patients receiving at least 2 visits from social workers, chaplains or spiritual counselors, licensed practical nurses or aides in the last 7 days of life.

Prior to adding a quality measure to Hospice Compare, CMS determines the reliability and validity of each quality measure to determine the scientific acceptability of each measure. CMS evaluates the quality measures using the NQF Measure Evaluation Criteria.[12] CMS also examines the distribution of the hospice-level denominator size for each quality measure to

[12] The NQF Measure Evaluation Criteria are on the NQF web site at http://www.quality.forum.org/Measuring_Performance/Sybmitting_Standards/Measure_Evaluation_Criteria.aspx#scientif.

assess whether the denominator is large enough to generate statistically reliable scores necessary for public reporting. CMS evaluated the "Hospice Visits when Death is Imminent" measure pair and determined that Measure 1 meets established standards for reliability, validity, and reportability and will be publicly reported in FY 2019. Measure 2 does not meet the readiness standards for public reporting and will not be publicly reported in FY 2019. CMS believes Measure 2 provides important information and will be included in each hospice's confidential Quality Measure Report available on the Certification and Survey Provider Enhanced Reporting (CASPER) system. CMS intends to conduct additional testing on Measure 2 to determine if and how the measure specifications may be modified or re-specified.

CMS notes that the data collection requirements for the measure pair will not change and the measure is not being removed from the HQRP. CMS proposes continued collection of the data for both Measure 1 and Measure 2 to allow additional testing and to make a determination about the public reporting of Measure 2 by the end of FY 2020.

CMS received some comments supporting its proposal for the measure pair as well as some providing suggestions for modifying Measure 2. Suggestions for changes include addressing higher levels of care and shorter lengths of stay, including RN visits in the definition, and capturing whether patients or their families declined a visit in the last days of life. CMS notes that it will consider all of the commenters' specific suggestions during the testing process for the measure.

Display of Publicly Available Government Data on the Hospice Compare Website. In the FY 2019 Hospice Final Rule (83 FR 38649), CMS finalized plans to publicly post information from the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (PUF) and other publicly available CMS data to the Hospice Compare website.

CMS plans to post this PUF data under a new "General information" section of Hospice Compare in the summer of 2019. CMS will also include clear text explaining the purpose and use of this information and suggest consumers discuss this information with their healthcare provider. Three mock-up tables are included in the final rule: Table 16 (Level of Care Provided Information), Table 17 (Primary Diagnosis Information), and Table 18 (Location of Care Information).

Proposal to Post Information from Government Data Sources to the Hospice Compare Website. CMS finalizes its proposal to post information from other publicly available data, such as information from the Census Bureau, CDC and NIH, to the Hospice Compare website beginning as soon as FY 2020. This information may augment the General Information section. CMS notes that this data is not quality measures but presents supplementary information that will help consumers make an informed decision.

Some commenters supported public posting of other available data, some requested additional detail on what would be posted, others recommended seeking stakeholder input prior to doing so. CMS restates that it will engage with stakeholders via sub-regulatory processes to ensure that consumers understand the information and will provide mock-ups of the data for stakeholder feedback.

III. Regulatory Impact Analysis

CMS states that the overall impact of this final rule is an estimated net increase in Federal Medicare payments to hospices of $520 million or 2.7 percent, for FY 2020. This aggegate increase is simply a result of the hospice payment update percentage of 2.6 percent, but results vary by facility type and area of country. Variation among facilities and region is a result of two factors: (1) proposed rebased payments rates of CHC, IRC, and GIP (and the decreased RHC rate used to achieve budget neutrality), and (2) the FY 2020 wage index without the 1-year lag. Both of these payment revisions are implemented in a budget-neutral manner.

Table 24 in the final rule (recreated below) shows the combined effects of all the finalize proposals and the variation by facility type and area of country. In brief, proprietary (for-profit) hospices (66 percent of all hospices) will increase in hospice payments of 1.8 percent compared with payment increases of 3.8 percent, and 2.6 percent for non-profit and government hospices, respectively. The rebasing of CHC, IRC, and GIP largely accounted for the smaller increase in hospice payments within the for-profit hospice category. The impact on hospices also varies among regions of country – a direct result of the variation in the annual update to the wage index as well as the rebasing of CHC, IRC and GIP. Hospices providing services in the South Atlantic, Middle Atlantic and East North Central regions would experience the largest estimated increases in payments of 4.5 percent, 2.6 percent, and 2.6 percent respectively. In contrast, hospices serving patients in the West North Central and outlying regions will experience, on average, the lowest increases of 1.4 and -0.3 percent, respectively in FY 2020 payments.

This rule also includes a requirement to provide an election statement addendum, upon request, to hospital beneficiaries (or representatives), non-hospice providers and Medicare contractors effective October 1, 2020. CMS estimates that burden would be reduced for non-hospice providers, including institutional, non-institutional and pharmacy providers because less time would be spent trying to obtain needed information for treatment decisions and accurate claims submissions. Specifically, CMS estimates that this rule generates $5.2 million in annualized cost savings beginning in FY 2020.

Table 24. Impact to Hospices for FY 2020

	Hospices	Rebasing of CHC, IRC, and GIP	FY 2020 Updated Wage Data Without the 1 Year Lag	FY 2020 Hospice Payment Update Percentage	Total Impact for FY 2020
All Hospices	4,599	0.0%	0.0%	2.6%	2.6%
Hospice Type and Control					
Freestanding/Non-Profit	602	1.4%	0.0%	2.6%	4.0%
Freestanding/For-Profit	2,843	-0.8%	0.0%	2.6%	1.8%
Freestanding/Government	39	0.0%	-0.3%	2.6%	2.3%
Freestanding/Other	325	0.2%	0.1%	2.6%	2.9%

	Hospices	Rebasing of CHC, IRC, and GIP	FY 2020 Updated Wage Data Without the 1 Year Lag	FY 2020 Hospice Payment Update Percentage	Total Impact for FY 2020
Provider/HHA-Based/Non-Profit	396	0.7%	-0.1%	2.6%	3.2%
Provider/HHA-Based/For-Profit	196	-1.3%	-0.1%	2.6%	1.2%
Provider/HHA-Based/Government	101	0.4%	-0.1%	2.6%	2.9%
Provider/HHA-Based/Other	97	0.6%	0.1%	2.6%	3.3%
Subtotal: Freestanding Provider Type	3,809	0.0%	0.0%	2.6%	2.6%
Subtotal: Provider/HHA Based Provider Type	790	0.2%	-0.1%	2.6%	2.7%
Subtotal: Non-Profit	998	1.2%	0.0%	2.6%	3.8%
Subtotal: For Profit	3,039	-0.8%	0.0%	2.6%	1.8%
Subtotal: Government	140	0.2%	-0.2%	2.6%	2.6%
Subtotal: Other	422	0.3%	0.1%	2.6%	3.0%
Hospice Type and Control: Rural					
Freestanding/Non-Profit	154	0.4%	0.2%	2.6%	3.2%
Freestanding/For-Profit	329	-1.7%	-0.1%	2.6%	0.8%
Freestanding/Government	20	-0.9%	-0.3%	2.6%	1.4%
Freestanding/Other	45	-1.3%	0.0%	2.6%	1.3%
Provider/HHA-Based/Non-Profit	157	0.6%	-0.2%	2.6%	3.0%
Provider/HHA-Based/For-Profit	47	-1.6%	-0.2%	2.6%	0.8%
Provider/HHA-Based/Government	74	-0.7%	0.0%	2.6%	1.9%
Provider/HHA-Based/Other	54	-0.5%	0.3%	2.6%	2.4%
Hospice Type and Control: Urban					
Freestanding/Non-Profit	448	1.5%	0.0%	2.6%	4.1%
Freestanding/For-Profit	2,514	-0.7%	0.0%	2.6%	1.9%
Freestanding/Government	19	0.2%	-0.3%	2.6%	2.5%
Freestanding/Other	280	0.3%	0.1%	2.6%	3.0%
Provider/HHA-Based/Non-Profit	239	0.7%	0.0%	2.6%	3.3%
Provider/HHA-Based/For-Profit	149	-1.3%	-0.1%	2.6%	1.2%
Provider/HHA-Based/Government	27	1.4%	-0.2%	2.6%	3.8%
Provider/HHA-Based/Other	43	0.9%	0.0%	2.6%	3.5%
Hospice Location: Urban or Rural					
Rural	880	-0.8%	0.0%	2.6%	1.8%
Urban	3,719	0.1%	0.0%	2.6%	2.7%
Hospice Location: Region of the Country (Census Division)					
New England	158	0.0%	-0.7%	2.6%	1.9%
Middle Atlantic	282	0.2%	-0.2%	2.6%	2.6%

	Hospices	Rebasing of CHC, IRC, and GIP	FY 2020 Updated Wage Data Without the 1 Year Lag	FY 2020 Hospice Payment Update Percentage	Total Impact for FY 2020
South Atlantic	558	2.0%	-0.1%	2.6%	4.5%
East North Central	546	0.1%	-0.1%	2.6%	2.6%
East South Central	264	-0.4%	-0.2%	2.6%	2.0%
West North Central	406	-1.5%	0.3%	2.6%	1.4%
West South Central	887	-0.5%	-0.1%	2.6%	2.0%
Mountain	462	-0.6%	0.1%	2.6%	2.1%
Pacific	990	-1.5%	0.6%	2.6%	1.7%
Outlying	46	-2.7%	-0.2%	2.6%	-0.3%
Hospice Size					
0 - 3,499 RHC Days (Small)	1,004	-1.0%	0.2%	2.6%	1.8%
3,500-19,999 RHC Days (Medium)	2,131	-1.1%	0.0%	2.6%	1.5%
20,000+ RHC Days (Large)	1,464	0.3%	0.0%	2.6%	2.9%

Source: FY 2018 hospice claims data as of May 21, 2018 from the CCW RIFs, accessed May 2019.

Region Key: New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York;
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central=Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas