Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

[CMS-1675-F]

Summary of Final Rule

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I. Introduction and Background (pages 36639-36645)

On August 4, 2017, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (82 *FR* 36638-36685) a final rule updating the Medicare hospice payment rates, wage index, and the quality reporting requirements for fiscal year (FY) 2018. Page references given in this summary are to this published document.

CMS estimates that the overall impact of the final rule will be an increase of $180 million (1.0 percent) in Medicare payments to hospices during FY 2018.

This final rule describes current trends in hospice utilization and provider behavior as well as CMS efforts for monitoring potential impact. CMS discusses its annual rate setting changes, including the 1.0 percent update percentage (as required by statute) and the updated hospice cap amount for FY 2018. With respect to the Hospice Quality Reporting Program (HQRP) CMS finalizes eight measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS® Hospice Survey). CMS also discusses the public comments receive on two claims-based quality measures under consideration. In addition, CMS discusses its plans to publicly display quality measure data via Hospice Compare in August 2017.

CMS notes that wage index addenda will be available only through the internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html

The final 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 notes that the number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to nearly 1.4 million in FY 2016. Similarly, Medicare hospice expenditures have risen from $2.8 billion in FY 2000 to an estimated $16.5 billion in FY 2016. Almost one-third of the hospice claims in FY 2016 had one of these principal diagnoses: Alzheimer's disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Lung Cancer, and Senile Degeneration of Brain.

II. Provisions of the Final Rule (pages 36645-36681)

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

In the FY 2018 Hospice proposed rule, CMS provided a summary of analysis conducted on hospice length of stay, live discharge rates, skilled visits in the last days of life, and non-hospice spending (82 *FR* 20750). CMS notes in the final rule its plans to continue to monitor the impact of future payment and policy changes and intends to provide the industry with periodic updates in future rulemaking and/or announcements on the Hospice Center webpage at: https://www.cms.gov/Center/Provider-Type/Hospice-Center.html.

In response to a few comments about the ongoing analysis and the need to better target program integrity efforts, CMS notes it will continue to monitor hospice trends and vulnerabilities within the hospice benefit while also developing means by which to educate the larger provider community regarding appropriate billing practices.

CMS also notes that it is currently working on a process to allow hospice Notice of Elections (NOEs) to be submitted via electronic data interchange while also working on a redesign of hospice period data in its systems. CMS states that by doing so, this should help with more timely beneficiary status updates in the Medicare systems.

B. FY 2018 Hospice Wage Index and Rates Update

A summary of key data for the hospice payment rates for FY 2018 is presented below with additional details in the subsequent sections.

Summary of Key Data for Hospice Payment Rates for FY 2018			
Statutory hospice update (MACRA)			1.0%
Hospice aggregate cap amount			$28,689.04
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2017 Federal Rates Per Diem**	**FY 2018 Federal Rates Per Diem**
Routine Home Care (days 1-60)	68.71%	$190.55	$192.78
Routine Home Care (days 61+)	68.71%	$149.82	$151.41
Continuous Home Care, Full Rate = 24 hours of care, $40.68 hourly rate	68.71%	$964.63	$976.42
Inpatient Respite Care	54.13%	$170.97	$172.78
General Inpatient Care	64.01%	$734.94	$743.55
Service Intensity Add-on (SIA) payment, up to 4 hours			$40.68 per hour

1. FY 2018 Hospice Wage Index

For FY 2018, CMS finalizes its proposal to use the FY 2017 pre-floor, pre-reclassified hospital inpatient wage index to derive the applicable wage index values for the hospice program, and to continue its policy of not taking into account geographic reclassifications under the inpatient prospective payment system in determining payments for hospices.[1] The updated wage data are from hospital cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013 (FY 2013 cost report data). The hospice wage index for FY 2018 will be effective October 1, 2017 through September 30, 2018.[2]

In response to comments about the wage index in specific CBSAs, CMS refers readers to the FY 2016 Hospice Wage Index and Payment Rate Update (80 FR 47179 through 47180). CMS disagrees with a comment that no hospice should receive a wage index below the hospital rural floor and reiterates the hospice wage index does not contain a rural floor provision. Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L, 105-33) provides a rural floor provision that is specific only to hospitals. The hospice floor is applicable to all CBSAs, both rural and urban. Pre-floor, pre-reclassified hospital wage values below 0.8 are adjusted by a 15 percent increase subject to a maximum wage index value of 0.8.

CMS acknowledges the comments it received about adjustments to the methodology used to calculate the wage index for rural Puerto Rico and it will take these comments under consideration for any future policy considerations. CMS notes that there was an error in the Proposed FY 2018 Hospice Wage Index file for Puerto Rico - the value for rural Puerto Rico was listed as 0.4047 and the correct value is 0.4654.

2. Hospice Payment Update Percentage

For FY 2018, the hospice payment update percentage will be 1 percent. The 1 percentage update is required by statute – section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Normally, the hospice payment update percentage would have been based on the estimated inpatient hospital market basket update of 2.7 percent (the inpatient hospital market basket is used in determining the hospice update factor) reduced by a productivity adjustment as mandated by the ACA (currently estimated to be 0.6 percentage point) and further reduced by 0.3 percentage point as also mandated by the ACA. Thus, the hospice payment update percentage would have been 1.8 percent for 2018.

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.

[1] 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; based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

[2] The wage index applicable for FY 2018 is available on the CMS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.

3. FY 2018 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 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 2018, the budget neutrality factor for days 1 through 60 is 1.0017, and for days 61 and beyond the factor is 1.0005.[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 2018 hospice wage index and compared it to its simulation of total payments using the FY 2017 hospice wage index. By dividing payments for each level of care using the FY 2018 wage index by payments for each level of care using the FY 2017 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).

Lastly, the RHC rates will be increased by the FY 2018 hospice payment update percentage of 1.0 percent, adjusted by the SIA budget neutrality factor, and the wage index standardization factor. The FY 2018 payment rates for CHC, IRC, and GIP will be the FY 2017 payment rates increased by 1.0 percent, and adjusted by the associated wage index standardization factor.

Tables 12 and 13 of the final rule (reproduced below) list the preliminary FY 2018 hospice payment rates by care category.

[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.

[4] The budget neutrality adjustment calculation that will apply to days 1 through 60 is equal to 1 minus the ratio of SIA payments for days 1 through 60 to the total payments. 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 12: FY 2018 Hospice RHC Payment Rates

Code	Description	FY 2017 Payment Rates	SIA budget Neutrality Factor	Wage Index Standardization Factor	FY 2018 Hospice Payment Update	FY 2018 Payment Rates
651	Routine Home Care (days 1-60)	$190.55	x 1.0017	x 1.0000	x 1.01	$192.78
651	Routine Home Care (days 61+)	$149.82	x 1.0005	x 1.0001	x 1.01	$151.41

Table 13: FY 2018 Hospice Payment Rates for CHC, IRC, and GIP

Code	Description	2017 Payment Rate	Wage Index Standardization Factor	FY 2018 Hospice Payment Update	FY 2018 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care, $40.68 hourly rate	$964.63	x 1.0022	x 1.01	$976.42
655	Inpatient Respite Care	$170.97	x 1.0006	x 1.01	$172.78
656	General Inpatient Care	$734.94	x 1.0017	x 1.01	$743.55

Tables 14 and 15 of the final rule list the comparable FY 2018 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), $188.97; Routine Home Care (days 61+), $148.81; Continuous Home Care, $957.08; Inpatient Respite Care, $169.36; and General Inpatient Care, $728.83.

4. Hospice Cap Amount for FY 2018

By way of background, when the Medicare hospice benefit was implemented, 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, 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,

[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.

and revert back to the original methodology. CMS adds that the hospice aggregate cap amount for the 2018 cap year will be $28,689.04 per beneficiary or the 2017 cap amount updated by the FY 2018 hospice payment update percentage ($28,404.99 * 1.01).

C. Discussion Regarding Sources of Clinical Information for Certifying Terminal Illness

CMS reviews the requirements for a Medicare beneficiary to be eligible to elect the Medicare hospice benefit. To be eligible to elect the Medicare hospice benefit, the individual must have Medicare Part A and be certified as terminally ill as defined at §418.20. Section 418.22 (c) requires that for the initial 90-day period of hospice care, the hospice must obtain written certification statements from the hospice medical director or the physician member of the hospice interdisciplinary group, and the individual's attending physician, if the individual has an attending physician. In reaching a decision to certify, the hospice medical director or hospice physician designee reviews the clinical information for each hospice patient and provides written certification that the patient's anticipated life expectancy is 6 months or less. Section 418.25(b) requires the hospice medical director consider at least the following information: diagnosis of the terminal condition of the patient; other health conditions; and current clinically relevant information supporting all the diagnoses. The regulations for the admission requirements (§418.22(b)(2)) also require this clinical information and other documentation that supports the medical prognosis must accompany the certification and be filed in the medical record with the written certification. CMS notes that there is no requirement that the hospice medical director or the physician member of the hospice interdisciplinary group has a face-to-face encounter with the patient when initially certifying the patient as terminally ill. In addition, no visits to the patient are covered under the Medicare hospice benefit until the individual has been certified as terminally ill, an election statement has been signed, and a plan a care has been established.

In the FY 2015 Hospice final rule (79 *FR* 50470), CMS provided guidance on determining beneficiaries' eligibility for hospice, reiterating the hospice "is required to make certain that the physician's clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of a life expectancy of 6 months or less". In the proposed rule, CMS discussed ongoing concerns that some hospice patients may be inappropriately certified as terminally ill and the steps it has taken to clarify the requirements for certification of hospice eligibility.

In the proposed rule, CMS solicited comments for possible future rulemaking on amending §418.25(b) to specify that the medical record from the referring physician and/or the acute/post-acute facility would serve as the basis for the initial hospice eligibility determinations. The clinical information supporting a terminal prognosis would be obtained by the hospice prior to election of the benefit, when determining certification and subsequent eligibility. CMS noted this potential clarification in the regulatory text would be in alignment with the benefit eligibility criteria that the individual must be certified as terminally ill prior to receiving hospice services, and could not be determined by hospice documentation obtained after admission. CMS also solicited comments on amending §418.25(b) to specify that documentation of an in-person visit from the hospice medical director or the hospice physician member of the interdisciplinary group could be used as documentation to support initial hospice eligibility determinations, only if needed to augment the clinical information from the referring medical records.

CMS acknowledges the comments it received; a few commenters supported the regulations text changes while others thought the process already included review of the referring clinical documentation and a change in the regulations was not needed. CMS agrees with comments that the regulations at §418.22(b) specify that clinical information and other documentation that supports the patient's prognosis must accompany the certification.

CMS is not proposing a change in the regulations at this time. It plans to work with the Medicare Administrative Contractors (MACs) to confirm whether they are requesting the supporting documentation from the referring source when claims are selected for medical review, and if not, whether such information should be included in any additional documentation requests. CMS continues to encourage providers to use the full range of clinical documentation when certifying terminal illness. If CMS decides a change is needed in the regulations, it would do that through future rulemaking.

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

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. Any measure selected by the Secretary must have been endorsed by the consensus-based entity holding a contract for performance measures (currently held by the National Quality Forum (NQF)). However, the Secretary may specify measures that are not so endorsed as long as a feasible and practical measure has not yet been endorsed by the consensus-based entity and consideration is given to measures that have been endorsed by the consensus-based organization.

CMS discusses the various social risk factors that may affect measures in the HQRP and continues to reviewing reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE)[6] and the National Academies of Sciences, Engineering, and Medicine[7] on the issue of measuring and accounting for social risk factors in CMS' value-based purchasing and quality reporting programs. CMS also is waiting for the recommendations from the NQF trial on risk adjustment for quality measures.

CMS discusses the comments it received about accounting for social risk factors in measures in the HQRP. Although commenters were supportive of accounting for social risk factors, the majority of commenters thought that social risk factors should be used only for outcome quality measures. Commenters were not supportive of identifying risk factors for process measures or direct impacts of care that are under the hospice's control. Several commenters were concerned about the unintended consequences of risk adjustment, including discouraging providers from admitting patients with identified social risk factors.

In addition to support for CMS' suggested social risk factors, many commenters suggested adjusting for family dynamics, availability of an adequate caregiver, history of substance abuse

[6] https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs

[7] National Academies of Sciences, Engineering, and Medicine. 2017. Accounting for Social Risk Factors in Medicare Payment. Washington, DC: The National Academies Press.

in the family, and psychosocial acuity. A few commenters thought risk adjustment should be on a measure-specific basis as different social risk factors may affect different outcomes.

CMS responds it will continue to consider options to account for social risk factors that will allow it to view disparities and potentially incentivize improvement in care.[8] It will also consider providing feedback to providers on outcomes for individuals with social risk factors in confidential reports. CMS notes that any changes would be proposed through future notice and comment rulemaking.

1. Policy for Retention of HQRP Measures Adopted for Previous Payment Determinations

In the FY 2016 Hospice final rule, CMS finalized that measures adopted for the HQRP, beginning with a payment determination year, will be automatically adopted for all subsequent years unless CMS proposes to remove, suspend, or replace the measure.

CMS will propose removal of measures through the annual rulemaking process. CMS notes however, that if it believes continued collection of a measure raises potential safety concerns, it will promptly remove the measure form the HQRP and notify hospices through the various HQRP communication channels (i.e. email notification and Web postings).

2. Adopting Changes to Previously Adopted Measures

CMS discusses NQF's measure maintenance process through which NQF-endorsed measures are sometimes updated to incorporate changes that CMS does not consider substantial changes to the measure. If NQF makes only non-substantive changes to specifications for HQRP measures in the NQF's re-endorsement process, such as updated diagnosis or procedure codes, CMS will continue to utilize the measure in its new endorsed status. CMS will continue to use rulemaking to adopt substantive changes made by the NQF to the endorsed measures that have been adopted for HQRP. CMS states that it will make determinations about what constitutes a substantive vs. non-substantive change on each specific measure.

3. Previously Adopted Quality Measures for FY 2018 Payment Determination and Future Years

In the FY 2014 Hospice final rule (78 *FR* 48258), CMS finalized the Hospice Item Set (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.

Table 16 in the final rule (reproduced below) provides a summary of measures previously finalized for the FY 2019 annual payment update (APU).

[8] CMS refers the reader to the FY 2018 Inpatient Prospective Payment System final rule for a discussion of measure stratification by social risk factors in a consistent manner across all programs.

Table 16: Previously Finalized Quality Measures Affecting the FY 2019 Payment Determination and Subsequent Years

NQF Number	Measure Name	Payment Determination (APU) Year for Which the Quality Measure was First Adopted
NQF # 1641	Treatment Preferences	FY 2016
NQF # 1647	Beliefs/Values Addressed (if desired by the patient)	FY 2016
NQF # 1634	Pain Screening	FY 2016
NQF # 1637	Pain Assessment	FY 2016
NQF # 1639	Dyspnea Screening	FY 2016
NQF # 1638	Dyspnea Treatment	FY 2016
NQF # 1617	Patients Treated with an Opioid Who Are Given a Bowel Regimen	FY 2016
N/A	Hospice and Palliative Care Composite Measure – Comprehensive Assessment at Admission	FY 2019
N/A	Hospice Visits When Death is Imminent Measure Pair	FY 2019

Hospices are required to complete and submit a HIS-Admission and a HIS-Discharge record for each patient admission. In the FY 2015 Hospice final rule, CMS also finalized the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey to support quality measures based on patient and family experiences of care. Hospices failing to report quality data via the HIS for patient admissions occurring in 2017 will have their market basket update reduced by 2 percentage points in FY 2019.

CMS submitted the Hospice and Palliative Care Composite Process Measure for consideration for NQF endorsement (NQF#3235). When at least 4 quarters of reliable data is available for the Hospice Visits when Death is Imminent measure, CMS will submit this measure for NQF endorsement.

4. Measure Concepts Under Consideration for Future Years

CMS discusses two measure concepts that are underdevelopment:

- Potential Avoidable Hospice Care Transitions. This would be a claims-based measure focusing on transitions of care. CMS discussed this measure in the FY 2016 Hospice final rule (80 *FR* 47188 through 47189). CMS notes this measures has the potential to improve the quality of care at the end of life by reducing potentially avoidable hospice care transitions.

- Access to Levels of Hospice Care. This measure would access the rates at which hospice provide different levels of hospice care. The Medicare Hospice Benefit covers four levels of care: routine home care (RHC), continuous home care (CHC), general inpatient care (GIP) and inpatient respite care. CMS notes that measuring levels of care will incentivize hospice providers to provide the appropriate level of care to meet the needs of the patient and caregiver.

Many commenters agreed these measure areas were important. Many commenters, however, expressed concerns with using claims data for quality measures because of the limited range of data elements available in claims data. CMS acknowledges the limitations of claims data but discusses how claims data is appropriate to measure provider-level rate of process and outcomes in the two proposed areas. These measures will allow comparison of providers to their peers with relevant patient-level and hospice-level factors taken into account. CMS also states it is taking into account the limitations of claims data as it constructs the measure specifications. It also believes that the using claims data minimizes provider burden and expedites implementation of a measure.

Several commenters noted that the two high priority measure areas will capture relatively low-frequency events. CMS agrees but notes that low-frequency events can still reveal important quality issues. In addition, CMS discusses research findings that report considerable variation across hospice providers in both measure areas. In response to comments that these measures are more suitable as utilization measures instead of quality measures, CMS states that these measures are not simple utilization statistics but instead are designed to promote quality improvement. Numerous published studies showed the measures impact quality of care through some structure, process, or outcome of care. CMS discusses the specific comments it received about each of the measure priority areas and will consider these comments and suggestions as it continues to develop these measures.

CMS discusses the suggestions it received for future quality measures. CMS agrees with commenters that the development of outcome measures should be prioritized in future HQRP measure development.

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

In the FY 2016 Hospice final rule, CMS clarified and finalized its policy for when new providers need to begin reporting data to CMS. Specifically, as related to the date on the CMS Certification Number (CCN) notification letter:

- New providers must begin submitting HIS data on the date listed in the letterhead of the CCN notification letter.
- New providers receiving their CCN notification on or after November 1 of the preceding year involved would be excluded from any payment penalty for quality reporting purposes for the following FY.

If a provider receives their CCN notification letter and the date in the letterhead is November 5, 2017, the provider will begin submitting HIS data for patient admissions occurring on or after

November 5, 2017 but since the letter was dated after November 1st, the hospice provider would not be subject to any payment penalties for the FY 2019 APU (which is associated with the patients admissions occurring January 1, 2017 through December 31, 2017).

For purposes of the quality reporting program, hospices are evaluated on whether or not they submit data, not on their substantive performance level for the required measure.
In the FY 2014 Hospice final rule (78 *FR* 48258), CMS finalized that providers must use either the Hospice Abstraction Reporting Tool (HART), which is free to download and use, or vendor-designed software to complete HIS records. CMS reiterates that completed HIS files must be submitted via the QIES ASAP system and hospices have 30 days from a patient admission or discharge to submit the appropriate HIS record for the patient. CMS notes that the submission date is the date on which the completed record is submitted and accepted by the QIES ASAP system. The QIES ASAP validation edits are designed to monitor the timeliness of HIS submissions and the system will issue a warning on the Final Validation Report if the submission date is late. CMS states that timely submission of data is essential to ensure the reliability of the data.

New Data Collection and Submission Mechanism Under Consideration: Hospice Evaluation & Assessment Reporting Tool (HEART). CMS discusses the work RTI International has done in the development of a hospice patient assessment tool, preliminarily called the HEART. In support of the requirements in section 3004 of the Affordable Care Act, CMS notes the new data collection mechanism would serve two primary purposes: (1) To provide the quality data necessary for HQRP requirements and the current function of the HIS; and (2) provide additional clinical data that could inform future payment refinements. In the FY 2017 Hospice final rule (81 FR 52143) CMS discusses the development of the HEART in greater detail.

In response to comments, CMS reiterates the new data collection mechanism would replace the current HIS, but would not replace the CAHPS® Hospice Survey nor would it replace regular submission of claims data. CMS envisions HEART as a patient assessment tool. CMS does believe that HEART may provide data that could inform future payment refinements that would be subject to rulemaking. CMS states the tool needs to be scientifically rigorous and clinically appropriate for the hospice population, minimize the data collection burden on providers, and incorporates feedback from technical experts and the hospice community. CMS will provide further details on HEART development and testing through future rulemaking cycles and through sub-regulatory communication channels.

6. Previously Adopted APU Determination and Compliance Criteria for the HQRP

HIS Data Submission Timelines and Compliance Thresholds. In the FY 2016 Hospice final rule, CMS finalized that beginning with the FY 2018 payment determination, hospices must submit all HIS records within 30 days of the Event Data, which is the patient's admission date or discharge date:

- For the HIS-Admission record within 30 days of the admission (the submission date would be no later than the admission date plus 30 calendar days) and
- For the HIS-Discharge records within 30 days of the discharge (the submission date would be no later than the discharge date plus 30 calendar days).

CMS also established an incremental threshold for compliance with the timeliness requirement that is being implemented over a 3-year period with the following schedule:

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

Resources regarding the timeliness compliance threshold for HIS submissions can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html.

CAHPS® Participation Requirements for the FY 2018 APU Determination and Determinations for Subsequent Years. In the FY 2017 Hospice final rule, CMS finalized that to meet the HQRP requirements for FYs 2018 through 2020 APU determinations, hospices would collect survey data on a monthly basis for calendar year 2016 to qualify for the FY 2018 APU, calendar year 2017 to qualify for the FY 2019 APU, and calendar year 2018 for the 2020 APU determination.

CMS finalizes its proposal to continue these requirements for future years: for FY2021 APU payment determination, hospices would collect data on a monthly basis for calendar year 2019, for the FY 2022 APU payment determination, hospices would collect data on a monthly basis for calendar year 2020.

7. HQRP Submission Exemption and Extension Requirements for the FY 2019 Payment Determination and Subsequent Years

Extraordinary Circumstances Exemption and Extension. CMS allows hospices to request and for CMS to grant exemptions or extensions with respect to the reporting of required quality data when there are extraordinary circumstances beyond the control of the provider. Hospices must currently request an exemption or extension within 30 calendar days of the date the extraordinary circumstances occurred. CMS notes it has reevaluated this policy for other quality reporting programs, such as the Hospital Inpatient Quality Reporting Program, and for these programs has extended this time to 90 calendar days.

CMS finalizes its proposal to extend the deadline for submitting an exemption or extension request to 90 days from the qualifying event, which is preventing a hospice from submitting their quality data for the HQRP. CMS also extends this policy to also include CAHPS® Hospice

Survey data. Requests will still need to CMS via email to HospiceQRPReconsiderations@cms.hhs.gov. A request must contain all of the requirements as outlined on its Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Extensions-and-Exemption-Requests.html.

CMS can also grant extensions/exceptions to hospices that have not requested them when it determines that an extraordinary circumstance, such as an act of nature, affects an entire region or locale or if it determines that a systemic problem with the agency's data collection systems directly affected the ability of a hospice to submit data. CMS notes, however, that exceptions and extensions will generally not be granted for hospice vendor issues, fatal error messages preventing record submission, or staff error.

Volume-based Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2017 through December 31, 2017 are exempted from the CAHPS® Hospice Survey data collection and reporting requirements for the FY 2020 payment determination (corresponds to the 2018 calendar year data collection period). To qualify for this exemption, hospices must submit an exemption request form by December 31, 2018 (the form will be available at http://www.hospiceCAPHSsurvey.org). In the FY 2017 final rule, similar time frames were finalized for the FY 2021 APU and FY 2022 APU payment determination. CMS notes that if a hospice continues to meet the eligibility requirements for this exemption in future APU periods, the organization should request the exemption annually for every applicable FY APU period.

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). Accordingly, hospices that receive their Medicare CCN after January 1, 2018 are exempted from the FY 2020 APU CAHPS® Hospice requirements. Similarly, hospices notified about their Medicare CCN after January 1, 2019 are exempted form the FY 2021 APU CAHPS® Hospice Survey and hospices notified about their Medicare CCN after January 1, 2020 are exempted from the FY 2022 APU CAHPS® Hospice Survey requirements.

8. CAHPS® Hospice Survey Participation Requirements for the FY 2020 APU and Subsequent Years.

CMS started the national implementation of the CAHPS® Hospice Survey January 1, 2015. CMS refers readers to the extensive discussion of the Hospice Experience of Care Survey in that final rule (79 *FR* 50450 and 78 *FR* 48261-48266) for a description of the measurements involved and their relationship to the statutory requirement for hospice quality reporting. The survey received NQF endorsement (NQF #2651) and includes six composite measures (Hospice Team Communication, Getting Timely Care; Treating Family Member with Respect, Getting Emotional and Religious Support, Getting Help for Symptoms, and Getting Hospice Care Training) and two global ratings (Rating of Hospice and Willingness to Recommend Hospice).

CMS finalizes its proposal to include the following eight CAHPS® Hospice Survey measures for 2018:

- Rating of Hospice (MUC16-31)
- Hospice Team Communications (MUC16-32)
- Willingness to Recommend (MUC16-33)
- Getting Hospice Care Training (MUC16-35)
- Getting Timely Care (MUC16-36)
- Getting Emotional and Religious Support (MUC16-37)
- Getting Help for Symptoms (MUC16-39)
- Treating Family Member with Respect (MUC16-40)

a. Data Sources

The CAHPS® Hospice Survey is administered three ways: mail-only, telephone only, and mixed mode (mail with telephone follow-up of non-respondents). For FYs 2018 and 2019 APU determinations, to meet the CAHPS® Hospice Survey requirements for the HQRP, CMS finalized that hospice facilities must contract with a CMS-approved vendor to collect survey data for eligible patients on a monthly basis and report this data, on behalf of the hospice, by the quarterly deadlines. Vendor failure to submit data on time is the responsibility of the hospice.

Table 17 in the final rule (reproduced below) provides the deadlines for data submission for FYs 2020 through 2022.

Table 17: CAHPS® Hospice Survey Data Submission Dates for the APUs in FY 2020-2022

Sample Month[1]	Quarterly Data Submission Deadlines[2]
FY 2020 APU	
January-March 2018 (Q1)	August 8, 2018
Monthly data collection April-June 2018 (Q2)	November 14, 2018
Monthly data collection July-September 2018 (Q3)	February 13, 2019
Monthly data collection October-December 2018 (Q4)	May 8, 2019
FY 2021 APU	
January-March 2019 (Q1)	August 14, 2019
Monthly data collection April-June 2019 (Q2)	November 13, 2019
Monthly data collection July-September 2019 (Q3)	February 12, 2020
Monthly data collection October-December 2019 (Q4)	May 13, 2020
FY 2022 APU	
January-March 2020 (Q1)	August 12, 2020
Monthly data collection April-June 2020 (Q2)	November 12, 2020[3]
Monthly data collection July-September 2020 (Q3)	February 10, 2021
Monthly data collection October-December 2020(Q4)	May 12, 2021

[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.
[3]Second Wednesday is Veterans Day Holiday.

b. Measure Calculations

CMS adopts its proposals for scoring hospices on the CAHPS® Hospice Survey measures for public scoring. CMS reminds the reader that hospice scores on the CAHPS® Hospice Survey-based measures will not affect whether they are subject to the 2.0 percentage point payment reduction for hospices that fail to report the required data to be submitted. The 2.0 percentage

point reduction will only be applied based on whether the data were submitted according to CMS' requirements.

CAHPS® Hospice Survey scores for a given hospice will be displayed as "top-box" scores, with the national average top-box score for participating hospices provided for comparison. Top-box scores reflect the proportion of caregiver respondents that endorse the most positive response(s) to a given measure, such as the proportion that rate the hospice a 9 or 10 out of 10 (0 to 10 scale), or the proportion that report that they "always" received timely care. The top-box numerator for each question within a measure is the number of respondents that endorse the most positive response(s). The denominator includes all respondents eligible to respond to the question except for the Getting Hospice Care Training measure because this measure score is calculated only among those respondents who indicated their family member received hospice care at home or in an assisted living facility.

Additional information on the specifications of these measures, including details about the top-box scoring methodology, survey method (CMS refers to as mode) and case-mix adjustment is on the CAHPS® Hospice Survey webpage at http://www.hospiceahpssurvey.org/en/. For direct questions, CMS encourages hospices to contact the CAHPS® Hospice Survey Team at hospicecahpssurvey@HCQIS.org or telephone 1-844-472-4621.

Composite Survey-Based Measures. Unadjusted hospice scores on each composite CAHPS® Hospice Survey measure will be calculated by determining the proportion of "top-box" responses for each question within the composite and average these proportions over all the questions in the composite measure.

CMS provides the following example with a theoretical hospice facility that had 50 surveys completed and received the proportions of "top-box" responses through sample calculation that included 50 total responses on each question:

- 25 "top-box" responses on question one
- 40 "top-box" responses on question two
- 50 "top-box" responses on question three
- 35 "top-box" responses on question four
- 45 "top-box" responses on question five
- 40 "top-box" responses on question six

Based on the above responses, CMS will calculate the hospice's unadjusted measure score for public reporting as: Publicly Reported Score = (0.5 + 0.8 + 1 + 0.7 + 0.9 + 0.8)/ 6 = 0.78. The hospice has an unadjusted score of 0.78 or 78 percent for this measure for purposes of public reporting. An adjusted hospice score would be calculated by adjusting the score for each question for differences in the characteristics of decedents and caregivers across hospices and for mode (discussed below) and then averaged across questions within the measure. Additional information about scoring and risk adjustment can be found at http://www.hospiceahpssurvey.org/en/technical-specifications/.

Global Survey-Based Measures. Unadjusted hospice scores on the two global CAHPS® Hospice Survey measure will be calculated by determining the proportion of high-value to the survey questions over the total number of respondents.[9] CMS provides an example in which a hospice received 45 9- and 10-point ratings out of 50 responses and would receive a 0.9 or 90 percent unadjusted score which would be adjusted to account for differences in the characteristics of decedents and caregivers across hospices and modes.

Cohort. The CAHPS® Hospice Survey is administered to all eligible patients/caregivers – or a random sample thereof – who meet the eligibility criteria. Eligible patients, regardless of insurance or payment, can participate. An eligible patient is a decedent, 18 years or older: with death at least 48 hours following the last admission to hospice care, for whom there is a caregiver of record, whose caregiver is someone other than a non-familial legal guardian, and for whom the caregiver has a U.S. or U.S. Territory home address. Patients who are still alive, including those alive when discharged from the hospice, are not eligible to participate in the survey. In addition, decedents/caregivers who voluntary request that the hospice not reveal the patient's identity or not survey the patient/caregiver are excluded from the sample.

c. Risk Adjustment

CMS discusses the need to ensure fair comparisons in public reporting by adjusting for factors that are not directly related to hospice performance, such as patient mix. CAHPS® Hospice Survey measures are adjusted for decedent and caregiver characteristics known to be associated with systematic differences in survey responses.[10]

To ensure that comparisons between hospices reflect differences in performance rather than differences in patient and/or caregiver characteristics, publicly reported hospice scores will be adjusted for variations of these characteristics across hospices. CMS plans to perform this adjustment by using a linear regression model applied to all data within a quarter, with indicator variables for each hospice and each characteristic as an independent variable in the model.

CMS discusses an experiment it conducted to determine whether survey mode adjustments were needed to fairly compare CAHPS® Hospice Survey scores. CMS concluded the results indicated it needs to also adjust scores for the mode of survey administration. CMS will do a mode adjustment prior to the patient-mix adjustment. A mode adjustment value will be added or subtracted (depending on the mode) to each response to the survey by mail-only mode or mixed mode (mail and telephone). Responses obtained using telephone-only mode will not be adjusted since this is the reference mode.

CMS discusses comments it received about its proposals for scoring measures. In response to concerns about the timeframe for reporting CAHPS® Hospice Survey results publicly on Hospice Compare, CMS states it is planning on reporting scores using a rolling average over the most recent eight quarters. CMS discusses the need to present reliable data and include as large a

[9] For the global CAHPS® Hospice Survey measures, a score of 9 to 10 on the Rating of Hospice measure and a "Definitely Yes" for the Willingness to Recommend measure are considered high-value responses.

[10] Survey measures are adjusted for the lag time between patient death and survey response; decedent's age, primary diagnosis, and length of final episode of hospice care; payer; and caregiver's education, relationship to decedent, preferred language, language in which the survey was completed, and caregiver's age.

proportion of hospices as possible on the Hospice Compare site. CMS is willing to consider other options and welcomes more input from hospices. CMS notes it is conducting ongoing analyses of the characteristics of decedents for whom CAHPS® Hospice Surveys are completed and is considering a variety of means for sharing this information with hospices. In response to questions suggesting other questions for inclusion in the survey, CMS states it will think further about care planning and shared decision making in the future.

In response to comments about how CMS will incorporate the CAHPS® Hospice Survey scores on Hospice Compare, CMS states it is designing the Hospice Compare site to provide users with information that is understandable to the public. CMS anticipates providing hospice data on Hospice Compare in the winter of 2018.

9. HQRP Reconsideration and Appeals Procedures for the FY 2018 Payment Determination and Subsequent Years

CMS is continuing its established process for reconsideration and appeals for hospice providers who receive a noncompliance decision. CMS determines reporting compliance by successfully fulfilling both the CAHPS® Hospice Survey requirements and the HIS data submission requirements.

CMS states that any hospice submitting a reconsideration request must do so by submitting an email to CMS, sent to HQRPReconsiderations@cms.hhs.gov, containing all of the requirements listed on the HQRP web site. (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Reconsideration-Requests.html.) Any reconsideration requests received through any other mechanism, including the US Postal Service or phone, will not be considered as valid reconsideration requests.

CMS notifies hospices that are non-compliant with reporting requirements and provides instructions for requesting reconsideration. In addition to its current practice of sending the hospice provider a certified U.S. Postal Service letter, for FY 2017 CMS will allow providers access to electronic letters using the Certification and Survey Provider Enhanced Reports (CASPER). CMS also intends to disseminate communications about the availability of hospice compliance reports in CASPER through normal channels it uses to communicate to hospices and vendors. The list of providers compliant with the FY 2017 APU requirements can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.html.

10. Confidential Feedback Reports

In December 2016, CMS made available two provider feedback reports: The Hospice-Level Quality Measure Report and the Patient Stay-Level Quality Measure Reports. These reports are only available to each hospice using the CASPER system and are part of the CASPER reports known as Quality Measure (QM) Reports. Information about how to access the CASPER QM Reports is available at http://www.qtso.com/hospicetrain.html.

As new measures are implemented in the HQRP, CMS will expand the QM reports to allow providers to view data on additional HIS measures. CMS plans to provide hospices with preview reports of their data prior to the quarterly publication on the Compare site through the CASPER reporting system.

11. 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 a process for making hospice quality reported data publicly available on the CMS web site. The process will include an opportunity for hospice providers to review the data being made available.

In the FY 2017 final rule (81 *FR* 52183 through 52184), CMS noted that analysis done by RTI International showed that calculating and publicly displaying measures based on 12 months of data would allow for sufficient measure denominator size. Additional analysis showed that applying a minimum sample size of 20 stays and using rolling 12 month data to create quality measures, would exclude only about 10 to 29 percent of hospices from public reporting, depending on the measure. CMS determined that it could publicly report individual scores for each of the 7 HIS measures on a CMS Compare web site for hospice agencies. Hospices with a quality measure denominator size of smaller than 20 patient stays would not have the quality measure score publicly reported. CMS also stated that new measures would undergo reportability analysis to determine the measure's appropriateness for public reporting and the appropriate data selection period; CMS plans to report this information through future rulemaking

CMS anticipates pubic reporting of HQRP data on the CMS website will begin August 2017. CMS plans to offer opportunities for stakeholder engagement and education prior to the rollout of a CMS Hospice Compare website.

CMS will provide hospices 30 days to review their preview quality data prior to publicly reporting the information; the 30 days begins with the date on which they can access the report in the CASPER system. Hospices will be able to request review of their data by CMS during the 30-day preview period if they believe that errors in data submitted to CMS may have resulted in incorrect scores and can submit proof along with a correction action plan. CMS will review these requests and if it confirms that the errors affected the measures, it will suppress the measure on the Hospice Compare website for one time only and display the corrected measure during the subsequent quarterly refresh of the website. CMS will post the policies and procedures for providers to submit requests for review of their data on the CMS HQRP website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Public-Reporting.html. CMS also encourages hospices to use the CASPER QM Reports to review their HIS quality measures after they submit the HIS data to CMS. If a hospice determines that erroneous data has been submitted they should submit corrections by either modifying the existing HIS record or inactivate the existing record to correct their data.

CMS plans to publicly report data in the winter of 2018 on all eight CAHPS® Hospice Survey measures. Scores would be displayed based on eight rolling quarters of data and would initially

use survey data collect from caregivers of patients who died while receiving hospice care between April 1, 2015 and March 31, 2017. CMS will update the score quarterly and scores will be displayed only for hospices for which there are 30 or more completed questionnaires during the reporting period.

In the future, CMS also plans to include a quality rating system that gives each hospice a rating between 1 and 5 stars. The timeline for development and implementation of the star rating will be announced via the CMS HQRP webpage and in future rulemaking.

CMS also notes that on June 14, 2016 it posted a hospice directory and quality data on a public data set located at https://data.medicare.gov. This data directory will be refreshed quarterly. In December 2016, CMS also posted two hospice data files containing national level aggregate quality data regarding seven quality measures and CAHPS® Hospice Survey measures. CMS notes these data files are a one-time release to meet its goal to make quality data available prior to the release of Hospice Compare. Once the Hospice Compare website is released in August 2017, the official datasets used on the Compare website will be available at http://data.medicare.gov.

Several commenters were supportive of public reporting of hospice quality measures. In response to a commenter's concern that hospices not included in the public reporting due to not meeting the minimum denominator size for reporting may be disadvantaged, CMS discusses its plan to indicates on the Hospice Compare Web site when data is not displayed due to a small denominator size. CMS believes this approach, which is consistent with other quality reporting programs, will signal to consumers that the lack of data is not an indication of poor quality but a result of the hospice having too few admissions to allow reporting a reliable quality measure.

CMS agrees with a comment that the overall distribution and variability of the scores of the seven HIS quality measures that will be publicly displayed indicate that most hospices are performing at a high level. CMS notes, however, that RTI International's analysis shows that a low percentage of hospices have perfect scores for most measures and a small percentage of hospices have very low scores.[11]

CMS acknowledges commenters' detailed input on the development of a star rating methodology for hospice. CMS will announce the timeline for development and implementation of the star ratings in future rulemaking, which will provide additional opportunity to provide public feedback on the proposed star rating methodology.

III. Collection of Information Requirements (pages 36681-36682)

CMS provides a summary of the information collection burden related to the National Implementation of the CAHPS® Hospice Survey. CMS does not adopt any new updates or additional collections of information in this rule in regards to the Hospice Item set of its constituent quality measures.

[11] These results are available in the Measure Testing Executive Summary document posted on the "Current Measures" portion of the CMS HQRP web site at: https://www.cms.gov/Medicare/Quality-Initiativies-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html.

CMS shows the estimated annualized burden hours and costs to respondents for the national implementation of the CAHPS® Hospice Survey in Tables 18 and 19 in the final rule. CMS estimates about 951,000 respondents across 3,414 hospices will complete the survey. Each survey contains 47 items and it's expected to require an average administration time of 10.4 minutes. The annual total cost burden to respondents is expected to be $7.7 million annually, or about $8 per respondent.

IV. Regulatory Impact Analysis (pages 36682-36685)

CMS states that the overall impact of this final rule is an estimated net increase in federal Medicare payments to hospices of $180 million or 1.0 percent, for FY 2018. This increase is simply a result of the hospital payment update percentage of 1.0 percent. The aggregate impact of the annual update to the wage index is zero percent due to the hospice wage index standardization factors.

Table 20 in the final rule (reproduced below) shows the detailed estimated hospice impacts by facility type and area of country. Variation from the overall impact is due to distributional effects of the annual update to the wage index. In brief, proprietary (for-profit) hospices (63 percent of all hospices) are expected to have an increase in hospice payments of 1.1 percent compared with payment increases of 1.0 percent, and 0.7 percent for non-profit and government hospices, respectively. The projected overall impact on hospices varies most among regions of country – a direct result of the variation in the annual update to the wage index. Hospices providing services in the urban Pacific and rural Middle Atlantic regions will experience the largest estimated increases in payments of 1.7 percent and 1.6 percent, respectively. Hospices serving patients in rural areas in the outlying areas will experience a decrease of 0.9 percent in FY 2018 payments.

TABLE 20: Projected Impact to Hospices for FY 2018

	Number of Providers	Updated wage data (%)	FY 2018 Hospice Payment Update (%)	FY 2018 Total Change (%)
(1)	(2)	(3)	(4)	(5)
All Hospices	**4,355**	**0.0%**	**1.0%**	**1.0%**
Urban Hospices	3,381	0.0%	1.0%	1.0%
Rural Hospices	974	0.1%	1.0%	1.1%
Urban Hospices - New England	134	-0.7%	1.0%	0.3%
Urban Hospices - Middle Atlantic	252	0.1%	1.0%	1.1%
Urban Hospices - South Atlantic	430	-0.3%	1.0%	0.7%
Urban Hospices - East North Central	407	-0.1%	1.0%	0.9%
Urban Hospices - East South Central	159	0.0%	1.0%	1.0%
Urban Hospices - West North Central	233	-0.2%	1.0%	0.8%
Urban Hospices - West South Central	662	0.0%	1.0%	1.0%
Urban Hospices – Mountain	327	-0.1%	1.0%	0.9%
Urban Hospices – Pacific	736	0.7%	1.0%	1.7%
Urban Hospices – Outlying	41	-0.6%	1.0%	0.4%
Rural Hospices - New England	23	0.0%	1.0%	1.0%
Rural Hospices - Middle Atlantic	40	0.6%	1.0%	1.6%
Rural Hospices - South Atlantic	135	0.1%	1.0%	1.1%
Rural Hospices - East North Central	141	0.2%	1.0%	1.2%
Rural Hospices - East South Central	124	-0.1%	1.0%	0.9%
Rural Hospices - West North Central	181	0.2%	1.0%	1.2%
Rural Hospices - West South Central	180	0.1%	1.0%	1.1%
Rural Hospices – Mountain	101	0.2%	1.0%	1.2%
Rural Hospices – Pacific	46	0.3%	1.0%	1.3%
Rural Hospices – Outlying	3	-1.9%	1.0%	-0.9%
0 - 3,499 RHC Days (Small)	1,004	0.2%	1.0%	1.2%
3,500-19,999 RHC Days (Medium)	2,017	0.1%	1.0%	1.1%
20,000+ RHC Days (Large)	1,334	0.0%	1.0%	1.0%
Non-Profit Ownership	1,059	0.0%	1.0%	1.0%
For Profit Ownership	2,735	0.1%	1.0%	1.1%
Govt Ownership	155	-0.3%	1.0%	0.7%

	Number of Providers	Updated wage data (%)	FY 2018 Hospice Payment Update (%)	FY 2018 Total Change (%)
Other Ownership	406	-0.2%	1.0%	0.8%
Freestanding Facility Type	3,379	0.0%	1.0%	1.0%
HHA/ Facility-Based Facility Type	976	0.0%	1.0%	1.0%

Source: FY 2016 hospice claims data from the Chronic Condition Data Warehouse (CCW) Research Identifiable File (RIF) in June 2017.

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