CMS-1733-P

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS-1733-P]

RIN 0938-AU09

Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2021. This rule also proposes changes to the hospice wage index by adopting the most recent Office of Management and Budget statistical area delineations, with a 5 percent cap on wage index decreases. Finally, this proposed rule summarizes the changes to the hospice election statement finalized in the FY 2020 Hospice Wage Index and Rate Update final rule and effective for October 1, 2020; and provides hospices with a model election statement and sample addendum.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 9, 2020.

ADDRESSES: In commenting, refer to file code CMS-1733-P.

Comments, including mass comment submissions, must be submitted in one of

the following three ways (choose only one of the ways listed):

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

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

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1733-P,

P.O. Box 8010,

Baltimore, MD 21244-1850.

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

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

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1733-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

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

FOR FURTHER INFORMATION CONTACT:

For general questions about hospice payment policy, send your inquiry via email to: hospicepolicy@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

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

Wage index addenda will be available only through the internet on our website at: (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.)

I. Executive Summary

A. Purpose

This rule proposes updates to the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2021, as required under section 1814(i) of the Social Security Act (the Act). In addition, this rule proposes to adopt the most recent Office of Management and Budget (OMB) statistical area delineations and apply a 5 percent cap on wage index decreases; and proposes to sunset the Service Intensity Add-on (SIA) budget neutrality factor.

B. Summary of the Major Provisions

Section III.A.1 of this rule proposes to adopt the OMB statistical area delineations outlined in a September 14, 2018, OMB bulletin. Section III.A.2 proposes to apply a 5

percent cap on wage index decreases. Section III.B.1 proposes updates to the hospice wage index and makes the application of the updated wage data budget neutral for all four levels of hospice care. In section III.B.2 of this proposed rule we discuss the proposed FY 2021 hospice payment update percentage of 2.6 percent. Section III.B.3 of this proposed rule proposes to sunset the service intensity add-on budget neutrality factor (SBNF) and update the hospice payment rates. Section III.B.4 proposes the hospice cap amount for FY 2021 by the hospice payment update percentage discussed in section III.B.2 of this rule. Finally, section III.C discusses the modifications to the hospice election statement and the election statement addendum that were finalized in the FY 2020 Hospice final rule (84 FR 38484) and solicits comments on model examples of the modified election statement and the addendum.

C. Summary of Impacts

The overall economic impact of this proposed rule is estimated to be $580 million in increased payments to hospices for FY 2021.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of a terminally ill individual and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define "palliative care" as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and

choice (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

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

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

Under the Medicare hospice benefit, the election of hospice care is a patient choice and once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group is essential in the seamless provision of services. These hospice services are provided primarily in the individual's home. The hospice interdisciplinary group works with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and

maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary's care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

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

Hospices must comply with applicable civil rights laws,[1] including section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, under which covered entities must take appropriate steps to ensure effective communication with

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

patients and patient care representatives with disabilities, including the provisions of auxiliary aids and services. Additionally, they must take reasonable steps to ensure meaningful access for individuals with limited English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at: http://www.hhs.gov/ocr/civilrights.

B. Services Covered by the Medicare Hospice Benefit

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

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before care is provided by, or under arrangements made by, that hospice program; and that the written plan be

periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (described in section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act).

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

C. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and our regulations in 42 CFR part 418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment in one of four prospectively-determined rate categories of hospice care (RHC, CHC, IRC, and GIP), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected). This per diem payment is to include all of the hospice services and items needed to manage the

beneficiary's care, as required by section 1861(dd)(1) of the Act.

While payment is made to hospices is to cover all items, services, and drugs for the palliation and management of the terminal illness and related conditions, federal funds cannot be used for the prohibited activities, even in the context of a per diem payment. Recent news reports[2] have brought to light the potential role hospices could play in medical aid in dying (MAID) where such practices have been legalized in certain states. We wish to remind hospices that The Assisted Suicide Funding Restriction Act of 1997 (ASFRA) (Pub. L. 105-12) prohibits the use of federal funds to provide or pay for any health care item or service or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual including mercy killing, euthanasia, or assisted suicide. However, pursuant to section 3(b)(4) of ASFRA, the prohibition does not apply to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing or accelerating death.

1. Omnibus Budget Reconciliation Act of 1989

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

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[2] Nelson, R., Should Medical Aid in Dying Be Part of Hospice Care? Medscape Nurses. February 26, 2020. https://www.medscape.com/viewarticle/925769#vp_1.

2. Balanced Budget Act of 1997

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

3. FY 1998 Hospice Wage Index Final Rule

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

4. FY 2010 Hospice Wage Index Final Rule

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

5. The Affordable Care Act

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

In addition, sections 1814(i)(5)(A) through (C) of the Act, as added by section 3132(a) of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111-148), required hospices to begin submitting quality data, based on measures specified by the

Secretary of the Department of Health and Human Services (the Secretary), for FY 2014 and subsequent FYs. Beginning in FY 2014, hospices that fail to report quality data have their market basket percentage increase reduced by 2 percentage points.

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

6. FY 2012 Hospice Wage Index Final Rule

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

7. IMPACT Act of 2014

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

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

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50452) finalized a requirement that the Notice of Election (NOE) be filed within 5 calendar days after the effective date of hospice election. If the NOE is filed beyond this 5-day period,

hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing (79 FR 50474). Similar to the NOE, the claims processing system must be notified of a beneficiary's discharge from hospice or hospice benefit revocation within 5 calendar days after the effective date of the discharge/revocation (unless the hospice has already filed a final claim) through the submission of a final claim or a Notice of Termination or Revocation (NOTR).

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

In addition, the FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50496) provided background, eligibility criteria, survey respondents, and implementation of the Hospice Experience of Care Survey for informal caregivers. Hospice providers were required to begin using this survey for hospice patients as of 2015.

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

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

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we created two different payment rates for RHC that resulted in a higher base payment

rate for the first 60 days of hospice care and a reduced base payment rate for subsequent days of hospice care. We also created a SIA payment payable for services during the last 7 days of the beneficiary's life, equal to the CHC hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse (RN) or social worker that occurs during the last 7 days (80 FR 47177).

In addition to the hospice payment reform changes discussed, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47186) implemented changes mandated by the IMPACT Act, in which the cap amount for accounting years that end after September 30, 2016 and before October 1, 2025 would be updated by the hospice payment update percentage rather than using the CPI-U. This was applied to the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016. In addition, we finalized a provision to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the fiscal year for FY 2017 and thereafter. Finally, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47144) clarified that hospices would have to report all diagnoses of the beneficiary on the hospice claim as a part of the ongoing data collection efforts for possible future hospice payment refinements.

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

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52160), we finalized several new policies and requirements related to the HQRP. First, we codified our policy that if the National Quality Forum (NQF) made non-substantive changes to specifications for HQRP measures as part of the NQF's re-endorsement process, we would continue to utilize the measure in its new endorsed status, without

going through new notice-and-comment rulemaking. We would continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures we have adopted for the HQRP; determinations about what constitutes a substantive versus non-substantive change would be made on a measure-by-measure basis. Second, we finalized two new quality measures for the HQRP for the FY 2019 payment determination and subsequent years: Hospice Visits when Death is Imminent Measure Pair and Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission (81 FR 52173). The data collection mechanism for both of these measures is the HIS, and the measures were effective April 1, 2017. Regarding the CAHPS® Hospice Survey, we finalized a policy that hospices that receive their CMS Certification Number (CCN) after January 1, 2017 for the FY 2019 Annual Payment Update (APU) and January 1, 2018 for the FY 2020 APU will be exempted from the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) requirements due to newness (81 FR 52182). The exemption is determined by CMS and is for 1 year only.

11. FY 2020 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38487), we rebased the payment rates for CHC and GIP and set those rates equal to their average estimated FY 2019 costs per day. We also rebased IRC per diem rates equal to the estimated FY 2019 average costs per day, with a reduction of 5 percent to the FY 2019 average cost per day to account for coinsurance. We finalized the FY 2020 proposal to reduce the RHC payment rates by 2.72 percent to offset the increases to CHC, IRC, and GIP payment rates to implement this policy in a budget-neutral manner in accordance

with section 1814(i)(6) of the Act (84 FR 38496). We also finalized a policy to use the current year's pre-floor, pre-reclassified hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. Finally, in the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38505) we finalized modifications to the hospice election statement content requirements at § 418.24(b) by requiring hospices, upon request, to furnish an election statement addendum effective beginning in FY 2021. The addendum must list those items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions, increasing coverage transparency for beneficiaries under a hospice election.

III. Provisions of the Proposed Rule

A. Proposed Hospice Wage Index Changes

1. Proposed Implementation of New Labor Market Delineations

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On April 10, 2018, OMB issued OMB Bulletin No. 18-03 which superseded the August 15, 2017 OMB Bulletin No. 17-01. On September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018 OMB Bulletin No. 18-03. These bulletins established revisions to the delineations of Metropolitan Statistical Areas (MSA), Micropolitan Statistical Areas, and Combines Statistical Areas, and guidance on uses of the delineation in these areas. A copy of the September 14, 2018 bulletin is available online at: https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf. (We note, on March 6, 2020 OMB issued Bulletin 20-01 (available on the web at

https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf), and as discussed below was not issued in time for development of this proposed rule.) This bulletin states it "provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the Federal Register (75 FR 37246 - 37252), and Census Bureau data."

While the revisions OMB published on September 14, 2018, are not as sweeping as the changes made when we adopted the CBSA geographic designations for FY 2006, the September 14, 2018 bulletin does contain a number of significant changes. For example, there are new CBSAs, urban counties that have become rural, rural counties that have become urban, and existing CBSAs that have been split apart. We believe it is important for the hospice wage index to use the latest OMB delineations available in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. We further believe that using the most current OMB delineations would increase the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels. We are proposing to implement the new OMB delineations as described in the September 14, 2018 OMB Bulletin No. 18-04 for the hospice wage index effective beginning in FY 2021. As noted above, the March 6, 2020 OMB Bulletin 20-01 was not issued in time for development of this proposed rule. While we do not believe that the minor updates included in OMB Bulletin 20-01 would impact our proposed updates to

the CBSA-based labor market area delineations, if needed we would include any updates from this bulletin in any changes that would be adopted in the FY 2021 hospice final rule.

i. Micropolitan Statistical Areas

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

Based upon the 2010 Decennial Census data, a number of urban counties have switched status and have joined or became Micropolitan Areas, and some counties that once were part of a Micropolitan Area, have become urban. Overall, there are fewer Micropolitan Areas (542) under the new OMB delineations based on the 2010 Census than existed under the latest data from the 2000 Census (581). We believe that the best course of action would be to continue the policy established in the FY 2006 Hospice Wage Index final rule and include Micropolitan Areas in each state’s rural wage index. These areas continue to be defined as having relatively small urban cores (populations of

10,000 to 49,999). Therefore, in conjunction with our proposal to implement the new OMB labor market delineations beginning in FY 2021 and consistent with the treatment of Micropolitan Areas under the IPPS, we are proposing to continue to treat Micropolitan Areas as ‘‘rural’’ and to include Micropolitan Areas in the calculation of each state’s rural wage index.

ii. Urban Counties Becoming Rural

If we adopt the new OMB delineations (based upon the 2010 decennial Census data), a total of 34 counties (and county equivalents) that are currently considered urban would be considered rural beginning in FY 2021. Table 1 below lists the 34 counties that would change to rural status if we finalize our proposal to implement the new OMB delineations.

TABLE 1: Counties that Would Change to Rural Status

County Name	State	CBSA	CBSA Name
BAKER	GA	10500	Albany, GA
NEWTON	TX	13140	Beaumont-Port Arthur, TX
GOLDEN VALLEY	MT	13740	Billings, MT
WALKER	AL	13820	Birmingham-Hoover, AL
SIOUX	ND	13900	Bismarck, ND
FLOYD	VA	13980	Blacksburg-Christiansburg-Radford, VA
DE WITT	IL	14010	Bloomington, IL
FORD	IL	16580	Champaign-Urbana, IL
BUCKINGHAM	VA	16820	Charlottesville, VA
ARANSAS	TX	18580	Corpus Christi, TX
MC DONALD	MO	22220	Fayetteville-Springdale-Rogers, AR-MO
LE FLORE	OK	22900	Fort Smith, AR-OK
WELLS	IN	23060	Fort Wayne, IN
HOOD	TX	23104	Fort Worth-Arlington, TX
SOMERVELL	TX	23104	Fort Worth-Arlington, TX
HAMILTON	NE	24260	Grand Island, NE
BARRY	MI	24340	Grand Rapids-Wyoming, MI

KALAWAO	HI	27980	Kahului-Wailuku-Lahaina, HI
VAN BUREN	MI	28020	Kalamazoo-Portage, MI
SCOTT	IN	31140	Louisville/Jefferson County, KY-IN
TRIMBLE	KY	31140	Louisville/Jefferson County, KY-IN
BENTON	MS	32820	Memphis, TN-MS-AR
SIBLEY	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI
HICKMAN	TN	34980	Nashville-Davidson--Murfreesboro--Franklin, TN
GULF	FL	37460	Panama City, FL
CUSTER	SD	39660	Rapid City, SD
CAROLINE	VA	40060	Richmond, VA
WEBSTER	LA	43340	Shreveport-Bossier City, LA
PLYMOUTH	IA	43580	Sioux City, IA-NE-SD
UNION	SC	43900	Spartanburg, SC
PEND OREILLE	WA	44060	Spokane-Spokane Valley, WA
COLUMBIA	WA	47460	Walla Walla, WA
PULASKI	GA	47580	Warner Robins, GA
KINGMAN	KS	48620	Wichita, KS

iii. Rural Counties Becoming Urban

If we finalize our proposal to implement the new OMB delineations (based upon the 2010 decennial Census data), a total of 47 counties (and county equivalents) that are currently designated rural would be considered urban beginning in FY 2021. Table 2 below lists the 47 counties that would change to urban status.

TABLE 2: Counties that Would Change to Urban Status

County Name	State	CBSA	CBSA Name
GREENE	AL	46220	Tuscaloosa, AL
WASHINGTON	AL	33660	Mobile, AL
FRANKLIN	AR	22900	Fort Smith, AR-OK
LEVY	FL	23540	Gainesville, FL
STEWART	GA	17980	Columbus, GA-AL
TALBOT	GA	17980	Columbus, GA-AL
POWER	ID	38540	Pocatello, ID
FULTON	IL	37900	Peoria, IL
JOHNSON	IL	16060	Carbondale-Marion, IL
FRANKLIN	IN	17140	Cincinnati, OH-KY-IN

PARKE	IN	45460	Terre Haute, IN
WARREN	IN	29200	Lafayette-West Lafayette, IN
BOONE	IA	11180	Ames, IA
JASPER	IA	19780	Des Moines-West Des Moines, IA
GEARY	KS	31740	Manhattan, KS
CARTER	KY	26580	Huntington-Ashland, WV-KY-OH
ASSUMPTION	LA	12940	Baton Rouge, LA
MOREHOUSE	LA	33740	Monroe, LA
FRANKLIN	MA	44140	Springfield, MA
IONIA	MI	24340	Grand Rapids-Kentwood, MI
SHIAWASSEE	MI	29620	Lansing-East Lansing, MI
LAKE	MN	20260	Duluth, MN-WI
COVINGTON	MS	25620	Hattiesburg, MS
HOLMES	MS	27140	Jackson, MS
STONE	MS	25060	Gulfport-Biloxi, MS
COOPER	MO	17860	Columbia, MO
HOWARD	MO	17860	Columbia, MO
STILLWATER	MT	13740	Billings, MT
ANSON	NC	16740	Charlotte-Concord-Gastonia, NC-SC
CAMDEN	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC
GRANVILLE	NC	20500	Durham-Chapel Hill, NC
HARNETT	NC	22180	Fayetteville, NC
OTTAWA	OH	45780	Toledo, OH
CLARENDON	SC	44940	Sumter, SC
GIBSON	TN	27180	Jackson, TN
STEWART	TN	17300	Clarksville, TN-KY
HARRISON	TX	30980	Longview, TX
STERLING	TX	41660	San Angelo, TX
KING AND QUEEN	VA	40060	Richmond, VA
MADISON	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV
SOUTHAMPTON	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
FRANKLIN CITY	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
JACKSON	WV	16620	Charleston, WV
MORGAN	WV	25180	Hagerstown-Martinsburg, MD-WV
LINCOLN	WI	48140	Wausau-Weston, WI
ADJUNTAS	PR	38660	Ponce, PR
LAS MARIAS	PR	32420	Mayagüez, PR

iv. Urban Counties Moving to a Different Urban CBSA

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to another urban CBSA under our proposal to adopt the new OMB delineations. In other cases, applying the new OMB delineations would involve a change only in CBSA name or number, while the CBSA continues to encompass the same constituent counties. For example, CBSA 19380 (Dayton, OH) would experience both a change to its number and its name, and become CBSA 19430 (Dayton-Kettering, OH), while all of its three constituent counties would remain the same. In other cases, only the name of the CBSA would be modified, and none of the currently assigned counties would be reassigned to a different urban CBSA. Table 3 below lists CBSAs where we are proposing to change either the name or CBSA number only.

TABLE 3: Counties that Would Change Name or CBSA Number

Proposed CBSA Code	Proposed CBSA Title	Current CBSA Code	Current CBSA Title
10540	Albany-Lebanon, OR	10540	Albany, OR
11500	Anniston-Oxford, AL	11500	Anniston-Oxford-Jacksonville, AL
12060	Atlanta-Sandy Springs-Alpharetta, GA	12060	Atlanta-Sandy Springs-Roswell, GA
12420	Austin-Round Rock-Georgetown, TX	12420	Austin-Round Rock, TX
13460	Bend, OR	13460	Bend-Redmond, OR
13980	Blacksburg-Christiansburg, VA	13980	Blacksburg-Christiansburg-Radford, VA
14740	Bremerton-Silverdale-Port Orchard, WA	14740	Bremerton-Silverdale, WA
15380	Buffalo-Cheektowaga, NY	15380	Buffalo-Cheektowaga-Niagara Falls, NY
19430	Dayton-Kettering, OH	19380	Dayton, OH
24340	Grand Rapids-Kentwood, MI	24340	Grand Rapids-Wyoming, MI
24860	Greenville-Anderson, SC	24860	Greenville-Anderson-Mauldin, SC
25060	Gulfport-Biloxi, MS	25060	Gulfport-Biloxi-Pascagoula, MS
25540	Hartford-East Hartford-Middletown, CT	25540	Hartford-West Hartford-East Hartford, CT

25940	Hilton Head Island-Bluffton, SC	25940	Hilton Head Island-Bluffton-Beaufort, SC
28700	Kingsport-Bristol, TN-VA	28700	Kingsport-Bristol-Bristol, TN-VA
31860	Mankato, MN	31860	Mankato-North Mankato, MN
33340	Milwaukee-Waukesha, WI	33340	Milwaukee-Waukesha-West Allis, WI
34940	Naples-Marco Island, FL	34940	Naples-Immokalee-Marco Island, FL
35660	Niles, MI	35660	Niles-Benton Harbor, MI
36084	Oakland-Berkeley-Livermore, CA	36084	Oakland-Hayward-Berkeley, CA
36500	Olympia-Lacey-Tumwater, WA	36500	Olympia-Tumwater, WA
38060	Phoenix-Mesa-Chandler, AZ	38060	Phoenix-Mesa-Scottsdale, AZ
39150	Prescott Valley-Prescott, AZ	39140	Prescott, AZ
23224	Frederick-Gaithersburg-Rockville, MD	43524	Silver Spring-Frederick-Rockville, MD
44420	Staunton, VA	44420	Staunton-Waynesboro, VA
44700	Stockton, CA	44700	Stockton-Lodi, CA
45940	Trenton-Princeton, NJ	45940	Trenton, NJ
46700	Vallejo, CA	46700	Vallejo-Fairfield, CA
47300	Visalia, CA	47300	Visalia-Porterville, CA
48140	Wausau-Weston, WI	48140	Wausau, WI
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	48424	West Palm Beach-Boca Raton-Delray Beach, FL

We are not discussing these proposed changes in this section because, in our view, they are inconsequential changes with respect to the hospice wage index. However, in other cases, if we adopt the new OMB delineations, counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. In another type of change, some CBSAs have counties that would split off to become part of or to form entirely new labor market areas. Finally, in some cases, a CBSA would lose counties to another existing CBSA if we adopt the new OMB delineations. Table 4 below lists the urban counties that would move from one urban CBSA to a newly or modified CBSA if we adopt the new OMB delineations.

TABLE 4: Counties that Would Change to a Different CBSA

Previous CBSA	New CBSA	County	State

16974	16984	COOK	IL
16974	16984	DU PAGE	IL
16974	16984	GRUNDY	IL
16974	20994	KENDALL	IL
16974	16984	MC HENRY	IL
16974	16984	WILL	IL
20524	39100	DUTCHESS	NY
20524	35614	PUTNAM	NY
26580	16620	LINCOLN	WV
28940	34100	GRAINGER	TN
35084	35154	SOMERSET	NJ
35614	35154	MIDDLESEX	NJ
35614	35154	MONMOUTH	NJ
35614	35154	OCEAN	NJ
35614	39100	ORANGE	NY
38660	49500	GUANICA	PR
38660	49500	GUAYANILLA	PR
38660	49500	PENUELAS	PR
38660	49500	YAUCO	PR

2. Proposed Transition Period

As discussed above, overall, we believe that our proposal to adopt the revised OMB delineations for FY 2021 would result in hospice wage index values being more representative of the actual costs of labor in a given area. However, we also recognize that some hospices would experience decreases in their area wage index values as a result of our proposal. We also realize that many hospices would have higher area wage index values under our proposal.

To mitigate the potential impacts of proposed policies on hospices, we have in the past provided for transition periods when adopting changes that have significant payment implications, particularly large negative impacts. For example, we have proposed and finalized budget neutral transition policies to help mitigate negative impacts on hospices following the adoption of the new CBSA delineations based on the 2010 decennial

census data in the FY 2016 hospice final rule (80 FR 47142). Specifically, we implemented a 1-year 50/50 blended wage

to the new OMB delineations. We applied a blended wage index for one year (FY 2016) for all geographic areas that would consist of a 50/50 blend of the wage index values using OMB's old area delineations and the wage index values using OMB's new area delineations. That is, for each county, a blended wage index was calculated equal to 50 percent of the FY 2016 wage index using the old labor market area delineation and 50 percent of the FY 2016 wage index using the new labor market area delineation, which resulted in an average of the two values. While we believed that using the new OMB delineations would create a more accurate payment adjustment for differences in area wage levels, we also recognized that adopting such changes may cause some short-term instability in hospice payments, in particular for hospices that would be negatively impacted by the proposed adoption of the updates to the OMB delineations. Therefore, we are proposing a transition policy to help mitigate any significant negative impacts that hospices may experience due to our proposal to adopt the revised OMB delineations. Specifically, for FY 2021 as a transition, we are proposing to apply a 5 percent cap on any decrease in a geographic area's wage index value from the wage index value from the prior FY. This transition would allow the effects of our proposed adoption of the revised CBSA delineations to be phased in over 2 years, where the estimated reduction in a geographic area's wage index would be capped at 5 percent in FY 2021 (that is, no cap would be applied to the reduction in the wage index for the second year (FY 2022)). We believe a 5 percent cap on the overall decrease in a geographic area's wage index value would be appropriate for FY 2021, as it provides predictability in payment levels from

FY 2020 to the upcoming FY 2021 and additional transparency because it is administratively simpler than our prior 1-year 50/50 blended wage index approach. We believe 5 percent is a reasonable level for the cap because it would effectively mitigate any significant decreases in a geographic area's wage index value for FY 2021. Because we believe that using the new OMB delineations would create a more accurate payment adjustment for differences in area wage levels we are proposing to include a cap on the overall decrease in a geographic area's wage index value.

Overall, the impact between the FY 2021 wage index using the old OMB delineations and the proposed FY 2021 wage index using the new OMB delineations would be 0.0 percent due to the wage index standardization factor, which ensures that wage index updates and revisions are implemented in a budget-neutral manner. We invite comments on our proposed transition methodology.

The proposed wage index applicable to FY 2021 can be found in on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice. The proposed hospice wage index for FY 2021 would be effective October 1, 2020 through September 30, 2021.

The wage index file also provides a crosswalk between the FY 2021 wage index using the current OMB delineations and the FY 2021 wage index using the proposed revised OMB delineations that would be in effect in FY 2021 if these proposed changes are finalized. This file shows each state and county and its corresponding proposed wage index along with the previous CBSA number, the new CBSA number or alternate identification number, and the new CBSA name.

B. Proposed Routine FY 2021 Hospice Wage Index and Rate Update

1. Proposed FY 2021 Hospice Wage Index

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

In the FY 2020 Hospice Wage Index final rule (84 FR 38484), we finalized the proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. In section III.A above we discuss our proposal to use the pre-floor, pre-reclassified hospital wage index data to calculate the hospice wage index values. For FY 2021, the proposed hospice wage index would be based on the FY 2021 hospital pre-floor, pre-reclassified wage index with a 5 percent cap on wage index decreases. This means that the hospital wage data used for the hospice wage index would reflect the new OMB delineations but would not take into account any geographic reclassification of hospitals including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The appropriate wage index value is applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the Core-Based Statistical Areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2021, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia. The FY 2021 adjusted wage index value for Hinesville-Fort Stewart, Georgia is 0.8539.

There exist some geographic areas where there were no hospitals, and thus, no hospital wage data on which to base the calculation of the hospice wage index. In the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term "contiguous" means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2021, we propose to continue to use the most recent pre-floor, pre-reclassified hospital

wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

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

The proposed hospice wage index applicable for FY 2021 (October 1, 2020 through September 30, 2021) is available on our website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.

2. Proposed FY 2021 Hospice Payment Update Percentage

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

1886(b)(3)(B)(iii) of the Act, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient market basket percentage increase for that FY.

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

The proposed hospice payment update percentage for FY 2021 is based on the current estimate of the inpatient hospital market basket update of 3.0 percent (based on IHS Global Inc.'s fourth-quarter 2019 forecast with historical data through the third quarter 2019). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the inpatient hospital market basket update for FY 2021 of 3.0 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.4 percentage point for FY 2021). In effect, the proposed hospice payment update percentage for FY 2021 would be 2.6 percent. If more recent data becomes available after the publication of this proposed rule and before the publication of the final rule (for example, more recent estimates of the inpatient hospital market basket update and MFP adjustment), we would use such data to determine the hospice payment update percentage for FY 2021 in the final rule.

Currently, the labor portion of the hospice payment rates is as follows: For RHC,

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

3. Proposed FY 2021 Hospice Payment Rates

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

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

(SBNF). The SBNF is used to reduce the overall RHC rate in order to ensure that SIA payment are budget-neutral. At the beginning of every fiscal year, SIA utilization is compared to the prior year in order calculate a budget neutrality adjustment.

As shown in Table 5, for FY 2016 through FY 2020, there have been very minor SBNF adjustments suggesting that the utilization of the SIA from one year to the next remains relatively constant. Because the SBNF remains stable, we are proposing to remove the factor to simplify the RHC payment rate updates. Therefore, the RHC payment rates would typically only be updated by the wage index standardization factor and the hospice payment update percentage. We invite comments on this proposal.

TABLE 5: FY 2016- FY 2020 SIA Budget Neutrality Factors

	Days 1-60	**Days 61+**
FY 2016	0.9806	0.9957
FY 2017	1.0000	0.9999
FY 2018	1.0017	1.0005
FY 2019	0.9991	0.9998
FY 2020	0.9924	0.9982

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. In order to calculate the wage index standardization factor, we simulate total payments using the FY 2020 hospice wage index and FY 2020 payment rates and compare it to our simulation of total payments using the FY 2021 wage index with a 5 percent cap on wage index decreases and FY 2020 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2020 wage

index and payment rates by payments for each level of care using the FY 2021 wage index and payment rates, we obtain a wage index standardization factor for each level of care. The wage index standardization factors for each level of care are shown in the tables below.

The proposed FY 2021 RHC rates shown in Table 6 will only be updated by the wage index standardization factor and the hospice payment update percentage as mentioned previously. The proposed FY 2021 payment rates for CHC, IRC, and GIP are shown in Table 7.

TABLE 6: Proposed FY 2021 Hospice RHC Payment Rates

Code	Description	FY 2020 Payment Rates	Wage Index Standardization Factor	Proposed FY 2021 Hospice Payment Update	Proposed FY 2021 Payment Rates
651	Routine Home Care (days 1-60)	$194.50	X 0.9989	X 1.026	$199.34
651	Routine Home Care (days 61+)	$153.72	X 0.9990	X 1.026	$157.56

TABLE 7: Proposed FY 2021 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2020 Payment Rates	Wage Index Standardization Factor	FY 2021 Hospice Payment Update	FY 2021 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care	$1,395.63	X 0.9991	X 1.026	$1,430.63 ($59.61 per hour)
655	Inpatient Respite Care	$450.10	X 0.9993	X 1.026	$461.48
656	General Inpatient Care	$1,021.25	X 0.9988	X 1.026	$1,046.55

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage

Index final rule (76 FR 47320 through 47324), we implemented a HQRP as required by section 3004 of the Affordable Care Act. Hospices were required to begin collecting quality data in October 2012, and submit that quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. The proposed FY 2021 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2021 hospice payment update percentage of 2.6 percent minus 2 percentage points. These rates are shown in Tables 8 and 9.

TABLE 8: Proposed FY 2021 Hospice RHC Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2020 Payment Rates	Wage Index Standardization Factor	Proposed FY 2021 Hospice Payment Update of 2.6% minus 2 percentage points = +0.6%	Proposed FY 2021 Payment Rates
651	Routine Home Care (days 1-60)	$194.50	X 0.9989	X 1.006	$195.45
651	Routine Home Care (days 61+)	$153.72	X 0.9990	X 1.006	$154.49

TABLE 9: Proposed FY 2021 Hospice CHC, IRC, and GIP Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2020 Payment Rates	Wage Index Standardization Factor	Proposed FY 2021 Hospice Payment Update of 2.6% minus 2 percentage points = +0.6%	Proposed FY 2021 Payment Rates
652	Continuous Home Care Full Rate= 24 hours of care	$1,395.63	X 0.9991	X 1.006	$1,402.74 ($58.45 per hour)

655	Inpatient Respite Care	$450.10	X 0.9993	X 1.006	$452.48
656	General Inpatient Care	$1,021.25	X 0.9988	X 1.006	$1,026.14

4. Proposed Hospice Cap Amount for FY 2021

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (Pub. L. 113-185). Specifically, for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. The proposed hospice cap amount for the FY 2021 cap year will be $30,743.86, which is equal to the FY 2020 cap amount ($29,964.78) updated by the proposed FY 2021 hospice payment update percentage of 2.6 percent.

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

In the FY 2020 Hospice final rule (84 FR 38484), we finalized modifications to the hospice election statement content requirements at § 418.24(b) to increase coverage transparency for patients under a hospice election. In addition to the existing election statement content requirements at § 418.24(b), we finalized that hospices also would be required to include the following on the election statement:

- Information about the holistic, comprehensive nature of the Medicare hospice benefit.
- A statement that, although it would be rare, there could be some necessary items, drugs, or services that will not be covered by the hospice because the hospice has

determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.

- Information about beneficiary cost-sharing for hospice services.
- Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that immediate advocacy is available through the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) if the beneficiary (or representative) disagrees with the hospice's determination.

Also in the CY 2020 hospice final rule, we finalized the requirements as set forth at § 418.24(c) for the hospice election statement addendum titled, "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" and would include the following content requirements:

1. Name of the hospice;
2. Beneficiary's name and hospice medical record identifier;
3. Identification of the beneficiary's terminal illness and related conditions;
4. A list of the beneficiary's current diagnoses/conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs, not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions;
5. A written clinical explanation, in language the beneficiary and his or her representative can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions and not

needed for pain or symptom management. This clinical explanation would be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs is related is made for each patient and that the beneficiary should share this clinical explanation with other health care providers from which they seek services unrelated to their terminal illness and related conditions;

6. References to any relevant clinical practice, policy, or coverage guidelines.

7. Information on:

a. the purpose of Addendum; and

b. the patient's right to immediate advocacy.

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

We finalized a policy requiring that the election statement modifications apply to all hospice elections. However, the addendum only would be furnished to beneficiaries, their representatives, non-hospice providers, or Medicare contractors who requested such information. Additionally, we finalized a policy that if the beneficiary (or representative) requested an addendum at the time of hospice election, the hospice would have 5 days from the start of hospice care to furnish this information in writing. Furthermore, if the beneficiary requested the election statement at the time of hospice election, but died within 5 days, the hospice would not be required to furnish the addendum as the requirement would be deemed to have been met in this circumstance. If the addendum was requested during the course of hospice care (that is, after the date of the hospice

election), we finalized a policy that the hospice would have 72 hours from the date of the request to provide the written addendum.

The election statement modifications and the election statement addendum requirements will be effective for hospice elections beginning on and after October 1, 2020 (that is, FY 2021). While we finalized the content requirements for the election statement addendum, we did not finalize a specific form, and hospices will develop and design the addendum to meet their needs, similar to how hospices develop their own hospice election statement.

Additionally, we finalized a policy that the signed addendum (and any signed updates) would be a new condition for payment. However, this does not mean in order to meet this condition for payment that the beneficiary (or representative), or non-hospice provider would have to agree with the hospice's determination. For purposes of this condition for payment, we finalized the policy that the signed addendum was only an acknowledgement of the beneficiary's (or representative's) receipt of the addendum (or its updates) and this payment requirement would be met if there was a signed addendum (and any signed updates) in the requesting beneficiary's medical record with the hospice. This addendum would not be required to be submitted routinely with each hospice claim. Likewise, the hospice beneficiary (or representative) would not have to separately consent to the release of this information to non-hospice providers furnishing services for unrelated conditions, because the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports,

diagnoses, and other medical information for treatment purposes without the patient's express authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient (45 CFR 164.506).

We delayed the effective date of the election statement content modifications and the hospice election statement addendum until FY 2021 to allow hospices adequate time to make the necessary modifications to their current election statements, develop their own election statement addendum, and make any changes to their current software and business processes to accommodate the requirements. Furthermore, in the FY 2020 Hospice final rule, we stated we would examine the operational and logistical issues highlighted by commenters in response to the election statement addendum to determine if any additional proposals would be required for FY 2021 rulemaking. These issues included concerns about the best way to furnish this information to patients and their representatives in the most clear and unobtrusive way; mechanisms to make necessary changes or adjustments to the addendum content; obtaining necessary signature(s) on the addendum; expected documentation in the hospice's medical record to determine whether the addendum was requested, when it was requested, whether it was present, and whether the condition for payment requirement has been met; expectations as to the auditing process by the Medicare Administrative Contractors (MACs) when an Additional Documentation Request (ADR) was made; and the provision of MAC and BFCC-QIO education.

As noted in the FY 2020 Hospice final rule (84 FR 38509), the hospice Conditions of Participation (CoPs) at § 418.52(a) require that during the initial

assessment visit, in advance of furnishing care, the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands. Furthermore, hospices are to inform the beneficiary of the services covered under the Medicare hospice benefit, as well as the scope of such services. The intent of this standard was to ensure that patients were aware of their potential out-of-pocket costs for hospice care, such as co-payments, so that they would not be surprised by financial concerns at this stressful time (73 FR 32097). Therefore, hospices are already tasked with providing detailed information on hospice services and limitations to those services to the patient upon election of the benefit. We believe that the addendum further complements these requirements by ensuring that the hospice informs them of any items, services, or drugs which the terminally ill individual would have to seek outside of the benefit. As we also noted in the FY 2020 Hospice final rule, we stated that we would furnish a modified model election statement and election statement addendum to provide the industry as they move forward making the changes to their own election statements and as they develop an addendum to communicate those items, services, and drugs they will not be covering because they have determined them to be unrelated to the terminal illness and related conditions. We have posted the modified model election statement and addendum on the Hospice Center webpage, https://www.cms.gov/Center/Provider-Type/Hospice-Center, to give hospices an idea as to the requirements and how they can develop their own forms. Because we detailed the content requirements in the FY 2020 Hospice final rule, we believe that hospices have been provided with specific information in order to develop their own election statement addendum without any further proposals. We expect to

issue an MLN Matters ® article to accompany this proposed rule to further educate the hospice community as to the election statement and addendum content requirements effective for hospice elections beginning on and after October 1 2020.

Regarding mechanisms to make any necessary changes or adjustments to the requested addendum content, hospices have the option to make updates to the addendum, if necessary, to include such conditions, items, services and drugs they determine to be unrelated throughout the course of a hospice election in a format that works best for their current processes. Hospices are already required to make updates to the plan of care at least every 15 days, or more often as the patient's condition warrants, in accordance with the requirements at § 418.56(d). Therefore, hospices already have systems in place to address and document the changing needs of the patient via the hospice plan of care. We would expect that hospices would adopt a similar process for making any necessary changes or adjustments to the election statement addendum. Moreover, we do not expect that there would be frequent changes to the addendum, especially as a patient continues in a hospice election and where most conditions are or become related to the terminal prognosis and therefore, the responsibility of the hospice to manage.

The hospice election statement has always required the signature of the electing individual (or their representative). This requirement has not changed with the modifications to the election statement and if the individual (or representative) requests the election statement addendum, the finalized requirements include the signature of the individual (or representative), as well as the date the addendum was signed. We would expect that the signature on the addendum would be similar to how each hospice obtains the individual's signature on the election statement itself. That is, if the individual

electronically signs the election statement, there is nothing prohibiting the hospice from having the addendum electronically signed. We note that it is at the contractor's discretion as to how they address patient/representative electronic signatures in their review of medical records, so hospices should confirm with their respective Medicare contractors as to the use of electronic signatures for beneficiary (or representative) signatures. However, the addendum is required to be furnished to the individual in writing so that the individual (or representative) can understand the information provided, make treatment decisions based on that information, and share such information with non-hospice providers rendering items and services to the individual. Therefore, the format of the addendum must be usable for the patient; most often we would expect that this would be in a hard copy format that the individual can keep for his/her own records, similar to how hospices are required by the hospice CoPs at § 418.52(a)(3) to provide the individual a copy of the notice of patient rights and responsibilities.

For purposes of this condition for payment, we finalized that the signed addendum is only acknowledgement of the beneficiary's (or representative's) receipt of the addendum (or its updates) and this payment requirement would be met if there was a signed addendum (and any signed updates) in the requesting beneficiary's medical record with the hospice. The hospice CoPs at § 418.104(a)(2) says that the patient's record must include "signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24." As the addendum is part of the election statement as set forth in § 418.24, then it is also a required part of the patient's record, if the addendum has been requested by the beneficiary (or representative).

We believe that a signed addendum connotes that the hospice had the discussion

about the addendum and its content. Likewise, in the event that the individual (or representative) did not request the addendum, we would expect hospices to document, in some fashion, that the addendum was discussed with the patient (or representative) at the time of admission, similar to how other patient and family discussions are documented in the hospice's clinical record. Hospices can develop a way to document whether or not the addendum was requested at the time of hospice election (or at any time throughout the course of hospice care). This could be done in checklist format or as anecdotal notes by the nurse. However, we did not propose a specific format in which to document such conversations and hospices can develop their own processes to incorporate into their current workflow. We believe careful documentation that the addendum was discussed and whether or not it was requested would be an essential step hospices could take to protect themselves from possible claims denials related to any absence of an addendum (or addendum update) in the medical record. The model election form and addendum posted on the Hospice Center webpage will provide one example as to how hospices can document that the addendum was discussed at the time of election. We believe that hospices are the best to determine how to assimilate this requirement into their current processes and that it is not necessary to propose a specific process, thereby creating extra burden for hospices.

For purposes of an ADR and to mitigate any concerns about situations in which there was no beneficiary (or representative) request for the addendum, hospices may submit any documentation as it relates to the presence or non-presence of the addendum, given that it is a condition for payment. That is, if the beneficiary (or representative) requested the election statement addendum, then the hospice should submit the signed

addendum as part of any ADR. And if the beneficiary (or representative) did not request the election statement addendum, then the hospice can submit any documentation in response to an ADR that indicates that no beneficiary (or representative) request for an addendum was made to ensure that it is clear that the hospice addressed the addendum with the beneficiary. We believe that this situation is similar to the patient-designated attending physician requirement on the hospice election statement. That is, the hospice attending physician must be identified by the beneficiary on the hospice election statement, but only if the beneficiary designates one. We are aware that many hospices have included a checkbox on their election statement to indicate when the beneficiary has opted not to designate an attending physician. Hospices may choose to adopt a similar process for the election statement addendum to ensure that they have documented those situations when a beneficiary does not request an addendum upon having been told of their right to request one.

However, we understand stakeholder concerns regarding potential claims denials in the event that there is no signed addendum in the beneficiary's hospice clinical record because it was not requested. While we believe that a consistent, comprehensive process for documenting when a beneficiary (or representative) does not request the addendum will help mitigate claim denial issues, upon display of this proposed rule, we have posted a model hospice election statement and addendum on the Hospice Center webpage (https://www.cms.gov/Center/Provider-Type/Hospice-Center) to assist hospices in understanding the content requirements. We remind hospices that the modifications to the election statement are effective for all hospice elections beginning on and after October 1, 2020. The model election statement posted on the Hospice Center webpage

illustrates how hospices can incorporate the finalized modifications into their own election statements. The model addendum, also posted on the Hospice Center webpage, demonstrates how hospices can include all of the addendum requirements in a format that could assimilate into their current processes. We are soliciting comments on both of these model examples to see if they are helpful in educating hospices in how to meet these requirements effective on October 1, 2020. Additionally, we will provide education to Medicare contractors to help ensure that these finalized policies are fully understood by all relevant stakeholders.

We are not proposing any changes to the policies finalized in the FY 2020 Hospice final rule regarding the election statement content modifications or the requirements for the election statement addendum as set forth at § 418.24. These finalized policies will be effective for all hospice elections beginning on and after October 1, 2020.

Note: There are no proposals or updates in this proposed rule to the Hospice Quality Reporting Program.

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually.

We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This proposed rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2021 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

B. Overall Impacts

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an estimated increase of $580 million in payments to hospices, resulting from the hospice payment update percentage of 2.6 percent for FY 2021. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2020 to FY 2021. Using the most recent data available at the time of rulemaking, in this case FY 2019 hospice claims data as of January 13, 2020, we apply the current FY 2020 wage index. Then, using the same FY 2019 data, we apply the FY 2021 wage index to simulate FY 2021 payments. Finally, we apply a budget

neutrality adjustment so that the aggregate simulated payments do not increase or decrease due to changes in the wage index.

Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) (having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal

governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

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

C. Anticipated Effects

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than $7.5 million to $38.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. HHS's practice in interpreting the RFA is to consider effects economically "significant" only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The effect of the FY 2021 hospice payment

update percentage results in an overall increase in estimated hospice payments of 2.6 percent, or $580 million. The distributional effects of the proposed FY 2021 hospice wage index do not result in a greater than 5 percent of hospices experiencing decreases in payments of 3 percent or more of total revenue. Therefore, the Secretary has determined that this rule will not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This rule will only affect hospices. Therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. The 2020 UMRA threshold is $156 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $156 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise

has Federalism implications. We have reviewed this rule under these criteria of Executive Order 13132, and have determined that it will not impose substantial direct costs on state or local governments.

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

Using the wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is $107.38 per hour, including overhead and fringe benefits (https://www.bls.gov/oes/current/oes_nat.htm). This proposed rule consists of approximately 15,000 words. Assuming an average reading speed of 250 words per minute, it would take approximately 0.50 hours for the staff to review half of it. For each hospice that reviews the rule, the estimated cost is $53.69 (0.50 hour x $107.38). Therefore, we estimate that the total cost of reviewing this regulation is $7,946.12 ($53.69 x 148 reviewers).

D. Detailed Economic Analysis

1. Proposed Hospice Payment Update for FY 2021

The FY 2021 hospice payment impacts appear in Table 11. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size), and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows the effect of using the FY 2021 updated wage data. This represents the effect of moving from the FY 2020 hospice wage index to the FY 2021 unadjusted hospice wage index with the old OMB delineations. The fourth column shows the effect of moving from the old OMB delineations to the new OMB delineations with a 5 percent cap on wage index decreases. The aggregate impact of the changes in columns three and four is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2021 hospice wage index. The fifth column shows the proposed FY 2021 hospice payment update percentage of 2.6 percent as mandated by section 1814(i)(1)(C) of the Act, and is consistent for all providers. The 2.6 percent hospice payment update percentage is based on an estimated 3.0 percent inpatient hospital market basket update, reduced by a 0.4 percentage point productivity adjustment. It is projected that aggregate payments would increase by 2.6 percent, assuming hospices do not change their service and billing practices. The sixth column shows the estimated total impact for FY 2021.

We note that simulated payments are based on utilization in FY 2019 as seen on Medicare hospice claims (accessed from the CCW in January of 2020) and only include

payments related to the level of care and do not include payments related to the service intensity add-on.

As illustrated in Table 10, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 10: Projected Impact to Hospices for FY 2021

Hospice Subgroup	Hospices	FY 21 Updated Wage Data	New OMB Delineations (5% Cap)	Market basket	Overall Total Impact
All Hospices	4,760	0.0%	0.0%	2.6%	2.6%
Hospice Type and Control					
Freestanding/Non-Profit	594	0.0%	0.1%	2.6%	2.7%
Freestanding/For-Profit	3,002	0.0%	0.0%	2.6%	2.6%
Freestanding/Government	39	0.2%	0.0%	2.6%	2.8%
Freestanding/Other	362	0.0%	-0.1%	2.6%	2.5%
Facility/HHA Based/Non-Profit	381	-0.1%	0.0%	2.6%	2.5%
Facility/HHA Based/For-Profit	204	0.1%	0.0%	2.6%	2.7%
Facility/HHA Based/Government	94	0.0%	0.1%	2.6%	2.7%
Facility/HHA Based/Other	84	0.2%	0.3%	2.6%	3.1%
Subtotal: Freestanding Facility Type	3,997	0.0%	0.0%	2.6%	2.6%
Subtotal: Facility/HHA Based Facility Type	763	0.0%	0.0%	2.6%	2.6%
Subtotal: Non-Profit	975	0.0%	0.0%	2.6%	2.6%
Subtotal: For Profit	3,206	0.0%	0.0%	2.6%	2.6%
Subtotal: Government	133	0.1%	0.0%	2.6%	2.7%
Subtotal: Other	446	0.0%	0.0%	2.6%	2.6%
Hospice Type and Control: Rural					
Freestanding/Non-Profit	147	0.3%	0.0%	2.6%	2.9%
Freestanding/For-Profit	335	0.1%	0.0%	2.6%	2.7%
Freestanding/Government	21	0.1%	0.0%	2.6%	2.7%
Freestanding/Other	48	0.1%	0.0%	2.6%	2.7%
Facility/HHA Based/Non-Profit	151	0.0%	0.0%	2.6%	2.6%
Facility/HHA Based/For-Profit	47	0.4%	0.0%	2.6%	3.0%
Facility/HHA Based/Government	68	0.0%	0.0%	2.6%	2.6%
Facility/HHA Based/Other	51	0.1%	0.0%	2.6%	2.7%
Facility Type and Control: Urban					
Freestanding/Non-Profit	447	0.0%	0.1%	2.6%	2.7%

Freestanding/For-Profit	2,667	0.0%	0.0%	2.6%	2.6%
Freestanding/Government	18	0.2%	0.0%	2.6%	2.8%
Freestanding/Other	314	0.0%	-0.1%	2.6%	2.5%
Facility/HHA Based/Non-Profit	230	-0.2%	0.0%	2.6%	2.4%
Facility/HHA Based/For-Profit	157	0.1%	-0.1%	2.6%	2.6%
Facility/HHA Based/Government	26	-0.1%	0.1%	2.6%	2.6%
Facility/HHA Based/Other	33	0.2%	0.4%	2.6%	3.2%
Hospice Location: Urban or Rural					
Rural	868	0.2%	0.0%	2.6%	2.8%
Urban	3,892	0.0%	0.0%	2.6%	2.6%
Hospice Location: Region of the Country (Census Division)					
New England	155	-0.9%	0.0%	2.6%	1.7%
Middle Atlantic	279	0.3%	0.1%	2.6%	3.0%
South Atlantic	562	0.1%	0.0%	2.6%	2.7%
East North Central	548	0.2%	0.0%	2.6%	2.8%
East South Central	261	0.0%	0.0%	2.6%	2.6%
West North Central	407	-0.6%	0.0%	2.6%	2.0%
West South Central	924	0.2%	0.0%	2.6%	2.8%
Mountain	484	-0.5%	0.0%	2.6%	2.1%
Pacific	1,094	0.1%	0.1%	2.6%	2.8%
Outlying	46	-0.7%	-0.1%	2.6%	1.8%
Hospice Size					
0 - 3,499 RHC Days (Small)	1,066	0.0%	0.0%	2.6%	2.6%
3,500-19,999 RHC Days (Medium)	2,142	0.0%	0.0%	2.6%	2.6%
20,000+ RHC Days (Large)	1,552	0.0%	0.0%	2.6%	2.6%

Source: FY 2019 hospice claims data from CCW accessed on January 13, 2020.

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 P**acific**= Alaska, California, Hawaii, Oregon, Washington
Outlying=Guam, Puerto Rico, Virgin Islands

E. Alternatives Considered

For the FY 2021 Hospice Wage Index and Rate Update proposed rule, we considered alternatives to the proposals articulated in section III.A. We considered not

adopting the OMB delineations. However, we have historically adopted the latest OMB delineations as we believe that implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. Additionally, we considered not implementing the 1-year 5 percent cap on wage index decreases. However, we decided that the 5 percent cap was a better option for the transition because it would mitigate potential negative impacts from the transition to the new OMB delineations and allow providers the opportunity to adjust to the changes in their wage index values gradually.

F. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in Table 11, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 11 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this proposed rule. This estimate is based on the data for 4,408 hospices in our impact analysis file, which was constructed using FY 2019 claims available in January 2020. All expenditures are classified as transfers to hospices.

TABLE 11: Accounting Statement: Classification of Estimated Transfers and Costs, From FY 2020 to FY 2021

Category	Transfers
Annualized Monetized Transfers	$ 580 million*
From Whom to Whom?	Federal Government to Medicare Hospices

*The net increase of $580 million in transfer payments is a result of the 2.6 percent hospice payment update compared to payments in FY 2020.

G. Regulatory Reform Analysis under EO 13771

Executive Order 13771, entitled ‘‘Reducing Regulation and Controlling Regulatory Costs,’’ was issued on January 30, 2017 (82 FR 9339, February 3, 2017) and requires that the costs associated with significant new regulations ‘‘shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.’’ It has been determined that this proposed rule is an action that primarily results in transfers and does not impose more than de minimis costs as described above and thus is not a regulatory or deregulatory action for the purposes of Executive Order 13771.

H. Conclusion

We estimate that aggregate payments to hospices in FY 2021 will increase by $580 million, or 2.6 percent, compared to payments in FY 2020. We estimate that in FY 2021, hospices in urban areas will experience, on average, 2.6 percent increase in estimated payments compared to FY 2020. While hospices in rural areas will experience, on average, 2.8 percent increase in estimated payments compared to FY 2020. Hospices providing services in the Middle Atlantic region would experience the largest estimated increases in payments of 3.0 percent. Hospices serving patients in areas in the New England and Outlying regions would experience, on average, the lowest estimated increase of 1.7 percent and 1.8 percent, respectively in FY 2021 payments.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Dated: March 24, 2020.

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Seema Verma,
Administrator,
Centers for Medicare & Medicaid Services.

Dated: April 9, 2020.

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Alex M. Azar II,
Secretary,
Department of Health and Human Services.

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