Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform (CMS-1449-F; RIN 0938-AR64)

Summary of Final Rule

The Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* on August 7, 2013 (*78 FR 48234 – 48281*)[1] a final to update Medicare's hospice payment rates and the wage index for FY 2014, and to continue the phase out of the wage index budget neutrality adjustment factor (BNAF). Including the FY 2014 15 percent BNAF reduction, the total 5 year cumulative BNAF reduction in FY 2014 will be 70 percent. The BNAF phase out will continue with successive 15 percent reductions in FY 2015 and FY 2016.

This final rule also:

- clarify how hospices are to report diagnoses on hospice claims;
- finalizes October 1, 2014 as the beginning date claims will be returned if the principal diagnosis on the claim form is "debility" or "adult failure to thrive";
- changes requirements for the hospice quality reporting program by discontinuing currently reported measures and implementing a Hospice Item Set with seven National Quality Forum (NQF) endorsed measures beginning July 1, 2014; and
- implements the hospice Experience of Care Survey on January 1, 2015.

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I. Impact of the Proposed Rule

CMS projects that the final rule will increase payments to hospices by $160 million or 1.0 percent for FY 2014. The final hospice payment update percentage for FY 2014 is 1.7 percent and changes to the FY 2014 hospice wage index, including a reduction to the BNAF by an additional 15 percent, for a total BNAF reduction of 70 percent (0.018461 or 1.8461%). The BNAF reduction is part of a seven year BNAF phase out that was finalized in the August 2009 FY 2010 Hospice Wage Index final rule.

Detailed impact estimates are displayed in Table 11 of the final rule (page 482780); the Appendix to this summary provides additional information. The following table shows the impact by major hospice category:

[1] The final rule is available at: http://www.gpo.gov/fdsys/pkg/FR-2013-08-07/pdf/2013-18838.pdf.

Anticipated Impact on Hospice Payments in FY 2014	
Hospice Type	**All Proposed Rate Changes**
All Hospices	1.0%
Urban Hospice	1.0%
Rural Hospice	1.1%
Types of Ownership:	
Voluntary	1.1%
Proprietary	0.8%
Government	1.0%
Hospice Base:	
Freestanding	0.9%
Home Health Agency	1.4%
Hospital	1.1%
Skilled Nursing Facility	1.0%

II. Diagnosis Reporting on Hospice Claims

In the proposed rule, CMS clarified existing ICD-9-CM coding guidelines. CMS is actively collecting and analyzing hospice data for evaluation of payment reform methodologies, as mandated in section 3132(a) of the Affordable Care Act (ACA). CMS notes that current coding practices do not allow them to appropriately determine whether case mix adjustment or other methods would be a reasonable approach to hospice payment reform.

CMS cites numerous documents supporting the need to report ICD-9-CM diagnosis codes correctly. HIPAA, federal regulations, and the CMS Hospice Claims Processing manual (Pub 100-04, chapter 11) all require that the ICD-9-CM Coding Guidelines be applied to the coding and reporting of diagnoses on hospice claims. In the July 27, 2012 FY 2013 hospice wage index notice, CMS clarified that all providers should code and report the principle diagnosis as well as all coexisting and additional diagnoses related to the terminal condition or related conditions.

A. ICD-9-CM Coding Guidelines

CMS highlights several problems with diagnosis codes on hospice claims forms and clarifies diagnosis-related coding policies for hospice claim forms. CMS does not expect that these clarifications will create any limitations to assessing hospice services.

1. Use of Nonspecific, Symptom Diagnoses.

According to the ICD-9- CM Coding Guidelines, codes under the classification "Symptoms, Signs, and Ill-defined Conditions" are not to be used as principal diagnoses when a related definitive diagnosis has been established by the provider. CMS' analysis of FY 2012 claims indicates that beneficiaries with a reported principal hospice diagnosis

of "debility" have multiple comorbid conditions that should have been reported; similar findings were found when the primary hospice diagnosis was "adult failure to thrive".

In the proposed rule, CMS clarified that "debility" and "adult failure to thrive" should not be used as principal hospice diagnoses on the hospice claim form. Further, when recorded as the principal diagnosis, CMS proposed beginning October 1, 2013, claims would be returned to providers for a more definitive principal diagnosis. Based on comments received, CMS acknowledges this may be a "paradigm shift" for some hospices and that additional time might be necessary for correct reporting of diagnosis on the claim. To provide additional time, CMS finalizes that beginning October 1, 2014 claims with the principal diagnosis of "debility" and "adult failure to thrive" will be returned to providers. CMS does, however, expect providers to begin this transition to correct coding immediately.

In response to the over 100 comments that CMS received on this issue, they reiterate that they made no new proposals regarding ICD-9-CM Coding Guidelines. CMS states they did make clarifications regarding coding for the selection of principal and additional diagnosis on hospice claims. CMS does not expect any hospice provider to have a professional coder complete claims. In response to comments that this clarifications will restrict access to hospice, CMS disagrees and discusses how "debility" and "adult failure to thrive" are nonspecific diagnosis and that the condition that the hospice medical director determines is the most contributory to the terminal prognosis should be reported as the principal diagnosis and all other related conditions as additional diagnoses. The final rule discusses in detail the importance of accurate coding, including providing examples of clinical narratives and corresponding appropriate coding.

In response to comments addressing concerns about identifying related conditions to the terminal condition, CMS discusses the intent of the hospice benefit is to provide "all-inclusive care for pain relief and symptom management for the terminal prognosis and related conditions". CMS notes that "unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services should be considered related". CMS also discusses that it is the responsibility of the hospice physician to document why a patient's medical need(s) would be unrelated to the terminal diagnosis.

In the final rule, CMS also discusses evidence that some hospices are not providing the full range of required hospice services, most notably drugs, through their per diem reimbursement to Medicare hospice beneficiaries. In addition to an OIG report[2], data analysis by Abt Associates, identified that some hospice-related drugs are being submitted through Part D prescription programs. Analysis shows that in 2010, 773,168 Medicare hospice beneficiaries were enrolled in Part D and almost 15% of these individuals received over 334,000 analgesic prescriptions, totaling $13,000,430, through Part D during their hospice enrollment. CMS notes they are continuing to analyze claims for Medicare hospice beneficiaries to ensure that hospice providers are covering the required services, drugs, supplies, and DME. CMS states that the hospice reimbursement

[2] OIG Report A-06-10-00059, June 2012

structure is a bundled payment and required services should not be unbundled by hospice providers.

Several commenters supported the need for the diagnosis clarifications and enforcement of existing coding guidelines.

2. Use of "Mental, Behavioral and Neural Developmental Disorders" ICD-9-CM Codes.

CMS reports that the top 20 claims-reported principal hospice diagnoses include codes under the classification of "Mental, Behavioral and Neural Developmental Disorders". These codes are not appropriate principal diagnoses per ICD-9-CM Coding Guidelines. Instead, codes in the category "Diseases of the Nervous System and Sense Organs" encompass diagnoses such as dementia, Alzheimer's disease and stroke, and are acceptable as principal diagnosis per ICD-9-CM coding guidelines.

In response to comments about specific coding issues, CMS reiterates that the ICD-9-CM codes in the classification, "Diseases of the Nervous System and Sense Organs" are the appropriate codes and these codes include unspecified dementia conditions.

3. Guidance on Coding of Principle and Other, Additional, and/or Co-existing Diagnoses.

Although ICD-9-CM coding guidelines specify that the circumstances of an inpatient hospital admission diagnosis are to be used in determining the selection of a principal diagnosis, this guideline is not always being adhered to for the selection of a principal hospice diagnosis. CMS does not understand why this discrepancy exists as ICD-9-CM coding guidelines are specific regarding principal diagnosis selection. In response to comments, CMS clarifies it is not requiring that the principal hospice diagnosis be the same diagnosis as the inpatient hospital diagnosis and again stresses the role of the physician certifying hospice care in determining the most appropriate diagnosis and additional related diagnoses that contribute to the terminal prognosis of the individual.

In the proposed rule, CMS also noted the importance of reporting other, additional, and/or coexisting diagnoses that are related to the terminal illness and related conditions on the hospice claim form. CMS noted that the hospice claim form allows up to 17 additional diagnoses on the paper claim and up to 24 additional diagnoses on the electronic claim. To be in compliance with existing policies, CMS expects hospice providers to report all coexisting or additional diagnoses related to the terminal illness and related conditions on the hospice claim. CMS notes that accurate coding will help to develop any payment reform model.

B. Transition to ICD-10-CM

ICD-10-CM will replace ICD-9-CM on October 1, 2014. CMS notes that the ICD-9-CM coding clarifications also pertain to ICD-10-CM. The proposed rule provides links to the "General Equivalence Mappings" (GEMs) for the mapping between ICD-9-CM and ICD-

10-CM for both diagnosis and procedure codes. In response to comments, CMS finalizes that they will provide additional time to implement ICD-10-CM coding change within hospice software systems until October 1, 2014, when all hospice claims will be required to use ICD-10-CM codes or be returned.

III. Update to the Hospice Quality Reporting Program (HQRP)

Under section 3004 of the ACA, hospices that fail to meet quality data submission requirements will receive a two percentage point reduction to the market basket update beginning in FY 2014. For the FY 2014 payment determination, hospices reported two measures: the NQF-endorsed measure for pain management (#0209) and a structural measure (that is not NQF-endorsed) for participation in a Quality Assessment and Performance Improvement (QAPI) program with at least 3 patient care quality indicators.

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Any measure selected must have been endorsed by the consensus-based entity holding a contract for performance measures (currently held by the National Quality Forum (NQF)). However, the Secretary may specify measures that are not so endorsed as long as a feasible and practical measure has not yet endorsed by the consensus-based entity and consideration is given to measures that have been endorsed by the consensus-based organization.

A. Quality Measures for Hospice Quality Reporting Program and Data Submission Requirements for Payment year FY 2015 and Beyond

CMS finalizes that the NQF #0209 pain measure and the requirement that hospice complete a check list and data source questions as part of the structural measure for the QAPI will not be required for the HQRP beyond the data submission for the FY 2015 payment determination.

CMS has two concerns with the current pain measure. First, the measure does not easily correspond with the clinical processes for pain management and second, there is a high rate of patient exclusion. Most commenters agreed with CMS' decision. In response to commenters who thought it was important to retain the measure, CMS notes that recent analysis confirms that due to exclusions, only a small percentage of patients admitted to hospice are represented by this quality measure and that they remain committed to developing an improved pain outcome measure.

B. Quality Measures for Hospice Quality Reporting Program and Data Submission Requirements for Payment year FY 2016 and Beyond

CMS finalizes the implementation of the Hospice Item Set (HIS) in July 2014. The HIS is a hospice patient-level item set that can be used by all hospices to collect and submit standardized data items about each patient admitted to the hospice. CMS contracted with RTI International to develop the HIS for use as part of the HQRP. RTI focused on NQF-endorsed measures that were used and/or tested with hospice providers, and the HIS

includes 7 NQF-endorsed measures (see Table below). CMS expects the HIS Paperwork Reduction Act (PRA) package to post shortly on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/index.html.

CMS finalizes that hospices will begin the use and submission of the HIS in July 2014. Hospices will be required to complete and submit an admission HIS and a discharge HIS for each patient admitted to the hospice on or after July 1, 2014, regardless of payer. Electronic data submission will be required for each HIS submission and CMS plans to make submission software available for the HIS to hospices at no cost. Hospice programs will be evaluated for purposes of the quality reporting program based on whether or not they submit data, instead of their performance level on the required measures. CMS plans to provide hospices with further information and details about the use of the HIS through a broad range of communication venues. CMS also plans to provide details on data collection and submission timing prior to implementation of the HRIS in July 2014.

CMS also plans to provide HIS reports to individual hospices on their performance on the measures calculated from the data submitted; the specifics of the reporting system and precisely when specific measures would be made available have not yet been determined.

Finalized in the FY 2014 Final Rule			
Data Collection	**Data Submission**	**APU Impact**	**Measure Name**
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Hospice & Palliative Care: Pain Screening, NQF #1634
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Hospice & Palliative Care: Pain Assessment, NQF #1637
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Hospice & Palliative Care: Dyspnea Screening, NQF #1639
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Hospice & Palliative Care: Dyspnea Treatment, NQF #1638
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Hospice & Palliative Care: Treatment Preferences, NQF #1641
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Patient Treated with an Opiod who are Given a Bowel Regimen, NQF #1617
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Beliefs/Values Addressed (if desired by patient), *modified* NQF #1647

CMS received several comments related to general data submission requirements. In response to comments that the proposed July 1, 2014 date for data submission was too soon, CMS states that vendors have been provided more than adequate time (greater than 12 months) to develop products. In addition, the data submission system will include validation and receipt processes that will serve as evidence of submission. CMS also notes that as is common with other quality reporting programs, they will propose

accommodations in the case of natural disaster or other extenuating circumstances in next year's rulemaking.

CMS received several comments supportive of the implementation of the HIS and the endorsed measures, but commenters raised concerns about the 7-day length of stay exclusion in the endorsed measures and the lack of an outcome measure. CMS agrees and notes that the ACA requires measures that have been endorsed by an endorsing body, currently the NQF, and they are willing to work with measure developers and stewards to make modifications where needed. In response to concerns about potential burden of the HIS on patients and families, CMS notes the HIS is not a patient assessment and is not intended to replace a hospice's current initial patient assessment. CMS also states that the discharge HIS is needed to provide an end date for the episode of care, to establish the length of stay exclusion for the HIS measures and notes that discharge HIS items are minimal.

CMS also received several comments about specific measures. CMS agrees with concerns about using measures that have "topped out" but they have no evidence that any of the proposed measures have demonstrated a ceiling effect. In response to comments raising concerns about CMS' time window modifications for NQF # 1647 measure, CMS states they have consulted NQF and received guidance that they are using a "modification of the NQF measure". CMS will monitor the measure reporting over time to inform future evaluation for maintenance of the measure's endorsement. CMS states that prior to implementation of the HIS, they will provide hospices with guidance and training materials, including a detailed user guide, that will provide additional clarification for hospices.

Using 2011 Medicare claims data, CMS estimates there will be approximately 1,089,719 HIS submissions across all hospices for a year. CMS estimates that there will be 582 HIS submissions by each hospice annually or 49 submissions monthly. The total combined time burden for completion of the Admission and Discharge Hospice Data Item Sets is estimated to be 29 minutes; this includes the total nursing time required for completion of the admission and discharge assessments and clerical or administrative staff person time. For each individual hospice, the annual cost is estimated to be $3,818.26; the estimated cost for each individual HIS submission is $13.11.

In response to comments about the above estimate, CMS recognizes that efforts and activities will be required to implement and use the HIS as part of the quality. CMS notes, however that specific training costs were not identified because calculating the training burden is outside the scope of the information collection requirements. CMS also states that the burden estimates for completing the HIS data items were based on the HIS pilot test.

C. Public Availability of Data Submitted

Section 1814(i)(5)(E) of the Act requires the Secretary to establish procedures for making any quality data submitted by hospices available to the public. The procedures ensure that

a hospice would have the opportunity to review the data before it is made public. In addition the Secretary is authorized to report quality measures on the CMS website.

CMS acknowledges the many steps required prior to data being publicly reported, and they do not anticipate that public reporting will be implemented in FY 2016; it may occur during the FY 2018 APU year. CMS will announce the timeline for public reporting of data in future rulemaking.

CMS notes that commenters were in favor of public reporting and that this information needed to be available to consumers. CMS will consider the suggestion to provide a comprehensive explanation of the relationships between quality measures selected for public reporting and quality of care as they develop proposals for public reporting.

D. Adoption of the CMS Hospice Experience of Care Survey for the FY 2017 Payment Determination and Subsequent FYs

CMS is developing a Hospice Experience of Care Survey questionnaire based on questionnaires already in the public domain, such as the Family Evaluation of Hospice Care. The survey seeks information from informal caregivers of patients who died while enrolled in hospices; the questionnaire would be fielded after the patient's death. Caregivers would be presented with a set of questions about their own experiences and the experiences of the patient and hospice care. Hospices would be required to offer the survey, but individual caregivers would respond only if they voluntarily chose to do so.

The Hospice Experience of Care Survey is undergoing development in accordance with the principles used in the development of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. CMS is obtaining input from consumers and stakeholders, drafting a version of the hospice questionnaire that could be tested with a small number of respondents in both English and Spanish, and providing pilot testing of the survey instrument after the development of the initial questionnaire is completed. The 60-day notice for field testing of the survey was published on April 4, 2013 (78 FR 20323) under CMS-10475 (OCN 0938-New).

CMS finalizes the following timeline for implementation of the survey:

- Hospices will contract with a CMS-approved vendor to conduct a "dry run" of the survey for at least 1 month in the first quarter of CY 2015.
- Hospices, contracting with vendors, will begin continuous monthly data collection starting April 1, 2015. CMS expects that data will be submitted quarterly. CMS has not finalized the deadlines doe data submission.
- The dry run for at least 1 month in the first quarter of CY 2015 plus 3 quarters of continuous monthly participation (April 1, 2015 through December 31, 2015) will be required to meet the pay for reporting requirement of the Hospice Quality Reporting Program for the FY 2017 APU.
- Subsequent APU determinations will be based on 4 quarters of continuous monthly participation from January 1 through December 31 of the relevant CY.

- CMS will exempt very small hospices from the survey requirements; hospices that have fewer than 50 unduplicated or unique deceased patients in CY 2014 would be exempt from the Hospice Experience of Care Survey data collection and reporting requirements for the FY 2017 payment determination. The due date for the exemption form will be stated in next year's rule. Hospices will need to submit their patient counts annually to CMS for each future APU period for the exemption.

CMS notes that as part of the national implementation, they will develop technical specifications for vendors to follow and will issue a detailed survey guidelines manual prior to the dry run. A website will be developed similar to the HCAHPS website (see www.hcahpsonline.org) or the HHCAHPS website (see https://homehealthcahps.org) with information such as detailed manuals, survey updates, and technical assistance.

CMS received comments about survey implementation and administration. CMS states that obtaining data from caregivers is too important to delay implementation. In response to comments about the financial burden associated with the survey, CMS states that they do not believe the annual burden to hospices will exceed the annual burden and costs for the implementation of HHCAHPS. In addition, small hospices can annually submit a Participation Exemption Request Form and will not incur survey costs. In response to concerns about the survey length, CMS states that the final survey will be shorter than the test survey.

With respect to the timing of the survey administration, CMS anticipates administrating the survey about two or three months following the death of the hospice patient and that there will be one survey mode, known as the mixed mode, that includes a mail survey and telephone follow-up for non-responders. CMS proposes to have a uniform standard for the designation of the survey respondent, the person listed in the hospice record as the primary caregiver or primary contact person.

In response to comments, CMS states that hospices will not be responsible for a certain response rate for the survey and that response to the survey is voluntary. All approved survey vendors, however, must follow the survey administration protocol to implement the survey. CMS notes they will be proposing the required sample size for all hospice's in next year's proposed rule.

E. Notice Pertaining to Reconsiderations Following APU Determinations

To be consistent with other establish quality recording programs, CMS used the proposed rule to notify providers of their intent to provide a process that would allow hospices to request reconsiderations pertaining to their FY 2014 and subsequent years payment determinations.

Specifically, as part of the reconsideration process for hospices beginning with the FY 2014 payment determinations, hospices found to be non-compliant with the reporting

requirements during a given reporting cycle will be notified of that finding. The purpose of the notification is to put hospices on notice of the following:

(1) they have been noncompliant with section 3004 of the ACA for the reporting cycle in question;

(2) they would be scheduled to receive a two percentage point reduction to the annual payment update to the applicable fiscal year;

(3) they may file a request for reconsideration if they believe that the finding of noncompliance is erroneous or that they have a valid and justifiable excuse for being noncompliant; and

(4) they must follow a defined process on how to file a request for reconsideration which would be described in the original notification.

CMS would reverse their initial finding of noncompliance if: (1) the hospice provides proof of full compliance with all requirements during the reporting period; or (2) the hospice was unable to comply but provided adequate proof of a valid excuse for this noncompliance.

CMS will provide additional details of the reconsideration process on the HQRP section of cms.gov and by program instructions.

IV. FY 2014 Hospice Wage Index and Rates Update

A. Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospice agencies to reflect local differences in area wage levels based on the location where those services are furnished. The hospice wage index is based on the wage index used to adjust payments for acute care hospitals under the Medicare inpatient prospective payment system (IPPS). CMS has consistently used the pre-floor, pre-reclassified hospital wage index when deriving the hospice wage index. For the FY 2014 hospice wage index, CMS finalizes using the 2013 pre-floor, pre-reclassified hospital wage index. CMS notes the final FY 2014 pre-floor, pre-reclassified hospital wage index does not contain OMB's new area delineations because those changes were not published until the IPPS proposed rule was in advanced stages of development (78 FR 27552). If CMS includes these new area delineations in the FY 2015 hospital wage index, those changes would also be reflected in the FY 2016 hospice wage index.

In response to comments, CMS states that the pre-floor, pre-reclassified hospital wage index, which is updated yearly and is used by many other CMS payment systems, is the most appropriate method available to account for geographic variances in hospice labor costs. They note that section 3137(b) of the Affordable Care Act required CMS to submit a report to Congress with a plan to reform the hospital wage index system. This report was submitted on April 11, 2012 and can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html.

B. FY 2014 Hospice Wage Index with an Additional 15 Percent Reduced Budget Neutrality Adjustment Factor (BNAF)

As described in the 1997 Hospice Wage Index final rule, inpatient hospital pre-floor and pre-classified wage index values are subject to either a budget neutrality adjustment or application of the wage index floor. Wage index values of 0.8 or greater are adjusted by the BNAF. The BNAF is an adjustment which increases the hospice wage index value. Therefore the BNF reduction is a reduction in the amount of the BNAF increase applied to the hospice wage index value. It is not a reduction in the hospice wage index value or in the hospice payment rate.

Starting in FY 2010, a seven-year phase out of the BNAF began with a 10 percent reduction in FY 2010, and additional 15 percent reductions in FY 2011 through 2013. In FY 2014 the phase out will continue with an additional 15 percent reduction for a total reduction of 70 percent. The unreduced BNAF for FY 2014 is 0.061538 (or 6.1538 percent). A 70 percent reduction to the BNAF is 0.018461 (or 1.8461 percent).

Addendum A and Addendum B with the FY 2014 wage index values for rural and urban areas are available at http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/Hospice/index.html. The hospice wage index for FY 2014 includes the BNAF reduction and will be effective October 1, 2013 through September 30, 2014.

In response to comments about the BNAF reduction, CMS states they will continue to monitor for unintended consequences associated with the BNAF reduction.

C. Hospice Payment Update Percentage

The final hospice payment update percentage for FY 2014 is 1.7 percent.

Since fiscal year 2002, hospice payment rates have been updated by the hospital market basket percentage increase for the fiscal year involved. The hospice payment update percentage for FY 2014 is based on the inpatient hospital market basket update of 2.5 percent (based on IHS Global Insights, Inc. first quarter 2013 forecast with historical data through the fourth quarter of 2012). As required by the ACA, the estimated inpatient hospital market basket update for FY 2014 must be reduced by an economy-wide productivity adjustment of 0.5 percentage points for FY 2014 and an additional ACA-mandated reduction of 0.3 percentage points. As a result, the final hospice payment update percentage for FY 2014 is 1.7 percent.

The labor and non-labor portions of the hospice rate are:

- Routine Home Care – labor 68.71 and non-labor 31.29 percent;
- Continuous Home Care – labor 68.71 and non-labor 31.29 percent;
- General Inpatient Care – labor 64.01 and non-labor 35.99 percent; and
- Respite Care – labor 54.13 and non-labor 45.87 percent.

D. Proposed Updated FY 2014 Hospice Payment Rates

For FY 2014 and for subsequent years, CMS finalizes their decision to use rulemaking as a means to finalize hospice payment rates. The final FY 2014 payment rates would be the FY 2013 payment rates increased by 1.7 percent and will be effective for care and services furnished on or after October 1, 2013 through September 30, 2014. These rates summarized in the table below are based on Tables 7 and 8 in the final rule.

Beginning in fiscal year 2014, hospices failing to report quality data will have their market basket update reduced by two percentage points. Hospices were required to begin collecting quality data in October 2012 and submit that quality data in 2013. Hospices failing to report quality data in 2013 will have their market basket update reduced by 2 percentage points in FY 2014.

Final FY 2014 Hospice Payment Rate Updates				
Code	**Description**	**FY 2013 Payment Rate**	**FY 2014 Payment Rate [a]**	**FY 2014 Payment Rate With 2 Percent Reduction [b]**
651	Routine Home Care	$153.45	$156.06	$152.99
652	Continuous Home Care	$895.56	$910.78	$892.87
655	Inpatient Respite Care	$158.72	$161.42	$158.24
656	General Inpatient Care	$682.59	$694.19	$680.54
[a] Based on FY 2014 final hospice payment update of 1.7 percent [b] Based on FY 2014 final hospice payment update of 1.7 percent minus 2 percentage points because hospice did not report required quality data in 2013				

A Change Request with the finalized hospice payment rates, a finalize hospice wage index, the Pricer for FY 2014 and the hospice cap amount for the cap year ending October 31, 2013 will be issued in the summer.

V. Update on Hospice Payment Reform and Data Collection

1. Hospice Payment Reform

As mandated in section 3132(a) of the ACA, CMS must reform hospice payments no earlier than October 2013 and is authorized to collect additional data that may be used to revise the hospice payment system. The proposed rule provided updates on hospice payment reform.

CMS notes that the proposed rule did not solicit comments on the hospice payment reform update and discussions. They will consider the comments they received as they move forward with hospice payment reform.

2. Additional Data Collection

In December 2012, CMS posted a document to the Hospice Center webpage describing additional data collection which they were considering. CMS notes that commenters were largely supportive of their suggestions to collect additional visit and NPI data on claims. Many suggested collecting data on DME, supplies, and drugs from cost reports instead of at the patient level. Several commenters were concerned about the cost of data collection. CMS expects to issue a Change Request detailing the upper upcoming data collection either this spring or summer.

CMS also notes that section 3132(a)(1)(C) of the ACA authorizes the collection of more data on hospice cost reports. CMS states the revisions to the hospice cost report and associated instructions will be published in the "near future" in the *Federal Register*.

CMS received many comments supportive of the suggestions to collect additional visit and NPI data on claims. Many commenters suggested collecting data on DME, supplies and drugs from cost reports instead of at the patient level. CMS states they appreciate the comments received and will consider the input as they implement any new data collection for hospices. CMS issued Change Request 8358 on Friday, July 26, 2013 detailing the new data collection requirements.

APPENDIX: OVERALL IMPACT

Table 11 in the final rule (page 48278) shows the estimated combined effects of the updated wage index, the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 70 percent) and the final 1.7 percent hospice payment percentage update as compared to estimated FY 2013 payments. The table below reproduces this data for indicated categories of hospice; additional data by region is provided in Table 11.

Table: Anticipated Impact on Medicare Hospice Payments in FY 2014

Category	No. of Hospices	No. of Routine Home Care Days in Thousands	Percent Change in Hospice Payments due to FY 2014 Wage Index Update	Percent Change in Hospice Payments due to Wage Index Update, and additional 15% Reduction in BNAF	Percent Change in Hospice Payments due to Wage Index Update, additional 15% Reduction in BNAF and Hospice Payment Percentage Update
All Hospices	3,569	62,945	-0.1%	-0.7%	1.0%
Urban	2,594	55,101	-0.1%	-0.7%	1.0%
Rural	975	7,844	-0.2%	-0.6%	1.1%
By Size/Days:					
0-3499 days (small)	841	1,373	-0.3%	-0.8%	0.8%
3500-19,999 days (medium)	1,815	17,403	-0.2%	-0.7%	1.0%
20,000+ days (large)	913	44,168	-0.1%	-0.7%	1.0%
Type of Ownership:					
Voluntary	1,080	23,296	0.0%	-0.5%	1.1%
Proprietary	2,002	32,992	-0.3%	-0.9%	0.8%
Government	487	6,656	-0.1%	-0.7%	1.0%
Hospice Base:					
Freestanding	2,569	50,665	-0.2%	-0.8%	0.9%
HH Agency	522	7,728	0.3%	-0.3%	1.4%
Hospital	458	4,430	0.0%	-0.6%	1.1%
SNF	20	122	0.0%	-0.7%	1.0%

Source: Provider data as of December 31, 2012 for hospice with claims filed in FY 2012, based on the 2012 standard analytic file (SAF).