MEDICARE PROGRAM; FY 2014 HOSPICE WAGE INDEX AND PAYMENT RATE UPDATE; HOSPICE QUALITY REPORTING REQUIREMENTS; AND UPDATES ON PAYMENT REFORM

SUMMARY

On April 29, 2013, the Centers for Medicare & Medicaid Services (CMS) released its proposed rule for the federal fiscal year (FY) 2014 changes to 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 BNAF reduction in FY 2014 will be 70 percent. The BNAF's phase out will continue with successive 15 percent reductions in FY 2015 and FY 2016. This proposed rule would also clarify how hospices are to report diagnoses on hospice claims, and proposes changes in the requirements for the hospice quality reporting program (HQRP). The proposed rule is scheduled for publication in the *Federal Register* on May 10, 2013 with a 60-day comment period (from the date of public display) closing on June 28, 2013. A Change Request with the finalized hospice payment rates, a finalized hospice wage index, the Pricer for FY 2014, and the hospice cap amount for the cap year ending October 31, 2013 would be issued in the summer.

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I. Impact of the Proposed Rule

CMS estimates the overall impact of this proposed rule to be an increase in payments to hospices of $180 million or 1.1 percent for FY 2014. This estimated impact on hospices is a result of the proposed hospice payment update percentage for FY 2014 of 1.8 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 (0.018449 or 1.8449%). 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 9 of the proposed rule; the Appendix to this summary provides additional information. The following table shows the impact by major hospice category:

Hospice Type	All Proposed Rate Changes
All Hospices	1.1%
Urban Hospice	1.1%

Rural Hospice	1.2%
Types of Ownership:	
Voluntary	1.2%
Government	1.1%
Proprietary	1.0%
Hospice Base:	
Freestanding	1.0%
Home Health Agency	1.5%
Hospital	1.2%
Skilled Nursing Facility	1.3%

II. Diagnosis Reporting on Hospice Claims

In this year's proposed rule, CMS clarifies 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. **CMS solicits comments regarding these coding guideline clarifications.**

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 FY2012 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".

CMS clarifies 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, the claim will be returned to the provider for a more definitive principal diagnosis.

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.

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.

CMS also notes 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 notes 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.

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.

III. Proposed 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 proposes 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 would not be required for the HQRP beyond the data submission for the FY 2015 payment determination. **CMS solicits comments on these proposals**.

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. **CMS solicits comments on their proposed options for measuring pain management.** One option is to use two NQF process measures related to pain: NQF #1634, pain screening and NQF #1637, pain assessment. Another proposal is to retain the current NQF measure #0209 until an outcome measure related to achieving patient comfort was available.

HQRP Measures			
Data Collection	**Data Submission**	**APU Impact**	**Measure Name**
1/1/2013-12/31/2013	4/1/2014	FY 2015 (10/1/2014)	Structural/QAPI measure
1/1/2013-12/31/2013	4/1/2014	FY 2015 (10/1/2014)	Pain Management, NQF #0209

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

CMS proposes 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 proposes that hospices begin the use and submission of the HIS in July 2014. Hospices would 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 would be required for each HIS submission and CMS plans to make submission software available for the HIS to hospices at no cost. Hospice programs would 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. If the proposal for using HIS is finalized, 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.

Proposed in the FY 2014 Proposed 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 Rx, NQF #1638
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Hospice & Palliative Care: Rx Preferences, NQF #1641
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Patient Rx with an Opiod & Given a Bowel Regimen, NQF #1617
7/1/2014-12/31/2014	Rolling	FY 2016 (10/1/2015)	Beliefs/Values Addressed (if desired), NQF #1647

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 addition to sending comments about the related information collection and recordkeeping requirements, comments can also be submitted to the:

Office of Information and Regulatory Affairs, OMB
Attention: CMS Desk Officer, [CMS-1449-P]
Fax: 202-395-6974 or Email: OIRA_submission@omb.eop.gov

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 and welcomes public comment on what they should consider when developing future proposals related to public reporting.**

D. Proposed Adoption of the CMS Hospice Experience of Care Survey for the FY 2017 Payment Determination and that of 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 proposes the following timeline for implementation of the survey:

- Hospices would 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, would begin continuous monthly data collection starting April 1, 2015. CMS expects that data would be submitted quarterly.
- CMS proposes that the FY 2017 APU determination, based in part on the survey, would include a 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).

- CMS proposes that subsequent APU determinations would be based on 4 quarters of continuous monthly participation from January 1 through December 31 of the relevant CY.
- CMS proposes to exempt very small hospices from the survey requirements; hospices that had fewer than 50 unique deceased patients in CY 2014 would be exempt for the FY 2017 payment determination.

CMS anticipates setting out the collection of information requirements and burden estimates in the proposed rule for CY 2015.

E. Notice Pertaining to Reconsiderations Following APU Determinations

To be consistent with other establish quality recording programs, CMS uses this 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 Rate 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. These data do not contain OMB's new area delineations, based on the 2010 Census, that were released on February 28, 2013. CMS notes that if they include these new area delineations in the FY 2015 hospital wage index, those changes would also be reflected in the FY 2016 hospice wage index.

Beginning in FY 2007, CMS has used the core-based statistical areas (CBSAs) exclusively to calculate wage index values. CMS has also adopted a policy that for urban labor markets without a hospital from which the hospital wage index data could be derived, all of the CBSAs within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for those areas. In FY 2014 the only CBSA without a hospital from which hospital wage data could be derived is 25980, Hinesville-Fort Stewart, Georgia. For rural areas without rural hospital wage data, CMS uses the average pre-floor, pre-reclassified hospital wage index data from all contiguous to represent a reasonable proxy for the rural area. This policy, however, does not recognize the unique circumstances of Puerto Rico - the only rural area without a hospital from which hospital wage data could be derived. CMS has not identified an alternative methodology for rural Puerto Rico and for FY 2014 they continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico which is 0.4047.

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 0.061498 (or 6.1498 percent). A 70 percent reduction to the BNAF is 0.018449 (or 1.8449 percent). The BNAF may be updated by the final rule based on availability of more complete data.

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 would be effective October 1, 2013 through September 30, 2014.

C. Hospice Payment Update Percentage

The proposed hospice payment update percentage for FY 2014 is 1.8 percent.

Since fiscal year 2002, hospice payment rates have been updated by the hospital market basket percentage increase for the fiscal year involved. The proposed 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 a productivity adjustment currently estimated to be 0.4 percentage points for FY 2014 and an additional ACA-mandated reduction of 0.3 percentage points. As a result, the proposed hospice payment update percentage for FY 2014 is 1.8 percent. If more recent data are subsequently available, CMS will use the data to update these calculations.

Currently 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 proposes to use rulemaking as a means to propose hospice payment rates. The proposed FY 2014 payment rates would be the FY 2013 payment rates increased by 1.8 percent, which is the proposed hospice payment update percentage for FY 2014. The proposed FY 2014 hospice payment rates would be effective for care and services furnished on or after October 1, 2013 through September 30, 2014.

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.

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 would continue to be issued in the summer.

V. Update on Hospice Payment Reform and Data Collection

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. CMS provides updates on hospice payment reform; there are no proposals for a revised payment system.

1. Update on Reform Options
CMS' hospice contractor, Abt Associates, is continuing to conduct research and analysis, to identify potential data collection needs, and to research and develop hospice payment options. Related information, including the Abt Hospice Study Technical Report, is available on the CMS Hospice Center webpage, at http://www.cmc.gov/Center/Provider-Type/Hospice-Center.html.

CMS continues to conduct analysis of payment reform model options. These models include a U-shaped model of resource use which MedPAC recommended. This model is based on MedPAC's finding that a hospice's cost typically follows a U-shaped curve, higher costs at the beginning and end of a stay and lower costs in the middle. Another option is to analyze whether a short-stay add-on payment, similar to the home health Low Utilization Payment Amount (LUPA) add-on, would improve payment accuracy in a per diem system.

a. Rebasing the Routine Home Care (RHC) Rate. CMS has found evidence of a potential misalignment between the current RHC payment rate and the cost of providing RHC. A detailed discussion of this issue is provided in the proposed rule and additional information is in the Abt Hospice Study Technical Report. CMS notes that any rebasing would be considered part of hospice payment reform and any savings achieved through the reduction of the RHC rate would need to be redistributed in a budget neutral manner.

b. Site of Service Adjustment for Hospice Patients in Nursing Facilities. CMS is considering an OIG recommendation to reduce payments to Medicare hospices for beneficiaries in nursing facilities who are receiving hospice care. The March 2012 MedPAC report noted that hospices with a higher share of their patients in nursing facilities have margins as high as 13.8 percent. MedPAC attributed these higher margins to possible efficiencies and to reduced workload due to an overlap in aide services and supplies provided by the nursing facility. CMS provides a detailed analysis of aide services provided to hospice facilities in nursing facilities in the proposed rule.

2. Reform Research Findings
The reader is referred to the Abt Hospice Study Technical Report for a discussion of research findings, including hospice cost report analyses.

3. 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*.

APPENDIX
OVERALL IMPACT

Table 9 in the proposed rule shows the combined effects of the updated wage data (the 2012 pre-floor, pre-reclassified hospital wage index) and of the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 70 percent), comparing estimated payments for FY 2013 to estimated payments for FY 2014. The FY 2013 payments used for comparison have a 55 percent reduced BNAF applied. The table below reproduces this data for indicated categories of hospice. Additional data by region is provided in Table 9.

Table: Anticipated Impact on Medicare Hospice Payments

Category	No. of Hospices	No. of Routine Health Care Days in Thousands	Percent Change in Hospice Payments due to FY 2014 Wage Index Change	Percent Change in Hospice Payments due to Wage Index Change and additional 15% Reduction in BNAF	Percent Change in Hospice Payments due to Wage Index Change, additional 15% Reduction in BNAF and Market Basket Update
All Hospices	3,545	85,390	-0.1%	-0.7%	1.1%
Urban	2,575	74,784	-0.1%	-0.7%	1.1%
Rural	970	10,606	-0.2%	-0.6%	1.2%
By Size/Days:					
0-3499 days (small)	587	1,0211	-0.4%	-0.9%	0.9%
3500-19,999 days (medium)	1,711	17,331	-0.2%	-0.7%	1.1%
20,000+ days (large)	1,247	67,037	-0.1%	-0.7%	1.1%
Type of Ownership:					
Voluntary	1,077	30,041	0.0%	-0.6%	1.1%
Government	486	8,911	-0.1%	-0.7%	1.1%
Proprietary	1,982	46,438	-0.2%	-0.8%	1.1%
Hospice Base:					
Freestanding	2,547	69,752	-0.2%	-0.8%	1.0%
HH Agency	521	9,848	0.3%	-0.3%	1.5%
Hospital	458	5,574	0.0%	-0.6%	1.2%
SNF	19	216	0.2%	-0.5%	1.3%

Source: Providers with hospice claims with dates of service between October 1, 2011 and September 30, 2012, based on the 2012 standard analytical file as of December 31, 2012.