To: NHPCO Members  
From: NHPCO Health Policy Team  
Date: April 30, 2013

**CMS Proposes Updates to the Wage Index and Payment Rates for Medicare Hospice Benefit**

**Summary**

On April 29, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule entitled FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform. [CMS-1449-P]. The proposed rule has comments on the following topics:

- FY2014 Hospice rates
- Clarification on coding requirements
- Hospice quality reporting
- Update on hospice payment reform options
  - U-shaped model of resource use
  - Short stay add-on payment
  - Case-mix
  - Rebasing the routine home care rate
  - Site of service adjustment for Hospice Patients in Nursing Facilities
  - Cost report analysis
- Additional data collection
- Cost Report changes

The proposed rule will officially be published in the Federal Register on May 10, 2013. Comments are expected to be due July 9, 2013.

**FY2014 Hospice Rates**

Beginning with the FY2014 rule, and for subsequent years, CMS is proposing to use rulemaking as the means to propose hospice payment rates. CMS estimates that in addition to the productivity adjustment reductions and market basket adjustments, providers should expect an additional 0.7% reduction due to the impact of BNAF on the wage index and other wage index variability. The payment update percentage is shown below:
Proposed FY2014 Hospice Payment Update Percentage

<table>
<thead>
<tr>
<th>Hospital Marketbasket</th>
<th>2.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Productivity adjustment reduction</td>
<td>-0.4%</td>
</tr>
<tr>
<td>• Hospice-specific marketbasket reduction</td>
<td>-0.3%</td>
</tr>
</tbody>
</table>

FY2014 Hospice Payment Update % | 1.8%

• Updated wage index | -0.7%

Estimated Final FY2014 Hospice Payment Update % | 1.1%

The proposed FY2014 rates are as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2013 Payment Rate</th>
<th>Multiply by the FY2014 Hospice Payment Update of 1.8%</th>
<th>FY2014 Proposed Payment Rate</th>
<th>Labor Share (Wage Component)</th>
<th>Non-Labor Share (Non-Wage Component)</th>
<th>FY2014 Sequestration Reduction 2% reduced by MAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>153.45</td>
<td>X 1.018</td>
<td>$156.21*</td>
<td>$107.33</td>
<td>$48.88</td>
<td>$153.08</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>$895.56</td>
<td>X1.018</td>
<td>$911.68*</td>
<td>$626.42</td>
<td>$285.26</td>
<td>$893.45</td>
</tr>
<tr>
<td></td>
<td>Full Rate = 24 hours of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hourly rate = $37.99</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$158.72</td>
<td>X 1.018</td>
<td>$161.58*</td>
<td>$87.46</td>
<td>$74.12</td>
<td>$158.35</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$682.59</td>
<td>X 1.018</td>
<td>$694.88*</td>
<td>$444.79</td>
<td>$250.09</td>
<td>$680.98</td>
</tr>
</tbody>
</table>

**Wage Index Tables**

The wage index tables for FY2014 have been issued as addenda to the FY2014 proposed rule and will not be published in the Federal Register. The tables are available on the CMS website. NHPCO will post the

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1 The ACA mandates that in FY2013 thru FY2019, the hospice payment update percentage will be reduced by an additional 0.3 percentage points.
wage index calculator and state-by-state charts in the coming days. Watch for their release at www.nhpco.org/regulatory

Sequestration

*The reductions due to sequestration are not calculated in the FY2014 proposed rates. Providers have been instructed to bill at the current rate, with reductions due to sequestration (minus 2 percent) taken by the Medicare Administrative Contractor (MAC) before payment is issued. If sequestration continues into FY2014, the payment rates would be 2% less than the proposed amount for FY2014.

Budget Neutrality Adjustment Factor (BNAF) phase-out

FY2014 marks the fifth year of the seven year phase out of the BNAF. This adjustment in the rates is calculated with the wage index values and is “invisible” to providers. The BNAF reductions will be fully implemented in FY2016.

Clarifications on Coding Requirements

Related vs. Unrelated Diagnosis Reporting on Claims:
- CMS states that “all of a patient’s coexisting or additional diagnoses” related to the terminal illness or related conditions should be reported on the hospice claims.

Analysis of FY2013 Q1 Claims Data:
- At least 72% of hospice providers still only report one diagnosis on the hospice claim.
- CMS is further clarifying that all providers should code and report the principal diagnosis as well as all coexisting and additional diagnoses related to the terminal condition or related conditions to more fully describe the Medicare patients they are treating.
- CMS is actively collecting and analyzing hospice data for evaluation of hospice payment reform methodologies

Related Conditions:
- CMS cites that the Medicare hospice benefit requires the hospice to cover all palliative care related to the terminal illness and related conditions.
- In the December 16, 1983 Hospice final rule, hospices are also to cover care for interventions to manage pain and symptoms (48 FR 56008). Clinically, related conditions are any physical or mental condition(s) that are related to or caused by either the terminal illness or the medications used to manage the terminal illness. In terms of related versus unrelated, CMS restates the communication in the December 16, 1983 Hospice final rule:
  “...we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case–by-case basis. It is our general view that ...
“hospices are required to provide virtually all the care that is needed by terminally ill patients” (48 FR 56010 through 56011). Therefore, unless there is clear evidence that a condition is unrelated to the terminal illness, all services would be considered related. It is also the responsibility of the hospice physician to document why a patient’s medical need(s) would be unrelated to the terminal illness.”

Use of Nonspecific, Symptom Diagnoses

Debility and “Adult Failure to Thrive:”
- CMS acknowledges that the primary diagnoses of hospice patients have shifted from cancers to non-cancer terminal illnesses.
- CMS clarifies that “debility” and “adult failure to thrive” SHOULD NOT be used as principal hospice diagnoses on the hospice claim form. When reported as a principal diagnosis, these would be considered questionable encounters for hospice care.
- Claims would be returned to the provider (RTPd) for a more definitive principal diagnosis. “Debility” and “adult failure to thrive” could be listed on the hospice claim as other, additional, or coexisting diagnoses. CMS expects providers to code the most definitive, contributory terminal diagnosis in the principal diagnosis field (using ICD-9-CM or ICD-10-CM codes, when implemented) with all other related conditions in the additional diagnoses fields for hospice claims reporting.

Use of “Mental, Behavioral and Neuro-developmental Disorders” ICD-9-CM Codes

Alzheimer’s and Other Dementias:
- These diagnoses are increasingly in the top twenty diagnoses reported by hospices.
- Several codes that fall under this classification that are frequently reported principal hospice diagnoses on hospice claims, but are not appropriate principal diagnoses per ICD-9-CM Coding Guidelines.
- CMS clarifies that it is imperative that hospice providers follow ICD-9-CM coding guidelines and sequencing rules for all diagnoses and pay particular attention to dementia coding as there are dementia codes found in more than one ICD-9-CM classification chapter and there are multiple coding guidelines associated with these dementia conditions.

Guidance on Coding of Principal and Other, Additional, and/or Co-existing Diagnoses

- CMS expects that complete, comprehensive coding will be applied to hospice claims submissions.
- Hospice providers are expected to report all coexisting or additional diagnoses related to the terminal illness and related conditions on the hospice claim to be in compliance with existing policy, and provide the data needed for evaluating potential hospice payment reform methodologies.
- Currently, the hospice claim includes a field for the patient’s principal hospice diagnosis, but allows for up to 17 additional diagnoses on the paper UB-04 claim, and up to 24 additional diagnoses on the 837I 5010 electronic claim.
CMS Clarification on Coding Principal and Other Diagnoses

CMS also offers the following clarification regarding coding of the principle and other diagnoses:

- ICD-9-CM coding guidelines state, to list first the diagnosis shown in the medical record to be chiefly responsible for the services provided and to list additional codes that describe any coexisting conditions.
- The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”
- The UHDDS defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay”.

Transition to ICD-10-CM

- Note the transition date to ICD-10-CM is October 1, 2014.
- A critical issue associated with the transition to ICD-10-CM involves the matter of crosswalking between the ICD-9-CM and ICD-10-CM code sets.
- Understanding crosswalking will be important to physicians during the transition phase when learning which new ICD-10 code to use in place of an ICD-9 code.
- “General Equivalence Mappings” (GEMs) is the authoritative source for crosswalking between ICD-10 and ICD-9. The GEMs files are available for free and can be downloaded from the NCHS website, [www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm).
- Hospices should not substitute crosswalking for learning and fully implementing ICD-10-CM into their procedures.

Hospice Quality Reporting

CMS has proposed a number of changes in requirements for the hospice quality reporting program:

1. **FY2014 Data Collection and Submission**: Data collection and submission for QAPI Structural measure and NQF #0209 will be discontinued. Data collection will continue through the end of cal; FY 2015 is the last payment determination year for these measures.

2. **Hospice Item Set (HIS)**: CMS has developed and tested a hospice patient-level item set to be used by all hospices to collect and submit standardized data items about each patient admitted to hospice. This standardized data collection tool, Hospice Item Set (HIS), will support quality reporting and will be used to collect data on seven NQF endorsed measures. Implementation is proposed to begin **July 1, 2014** and affects FY 2016 payment determination. The measures included in the tool are:
• NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
• NQF #1634 Pain Screening
• NQF #1637 Pain Assessment
• NQF #1638 Dyspnea Treatment
• NQF #1639 Dyspnea Screening
• NQF #1641 Treatment Preferences
• NQF #1647 Beliefs/Values Addressed (if desired by the patient)

Hospices who fail to report quality data via the HIS system in 2014 will have a 2% marketbasket reduction for FY2016.

3. **Public reporting on hospice quality measures:** Public reporting will not be initiated prior to 2017 and will be preceded by evaluation of appropriateness for use for public reporting and hospices’ review of their own results.

4. **Hospice Experience of Care Survey:** The Hospice Experience of Care Survey (Hospice CAHPS), currently under development, will be a post-death caregiver survey.
   - Hospices will be required to contract with a vendor for survey administration and quarterly data submission.
   - Hospices must participate in a “dry run” for at least 1 month in first quarter of CY 2015
   - Hospices must begin continuous participation April 1, 2015
   - Participation will affect the FY 2017 payment determination year
   - Hospices with fewer than 50 deaths from 1/1/2014 – 12/31/2014 will be exempt from requirements for FY 2017 payment determination

Hospices who fail to participate in the Hospice CAHPS survey will have a 2% marketbasket reduction in FY2017.

5. **Reconsiderations for hospice quality reporting requirements:** A process will be created to allow hospices that have been notified of non-compliance with hospice quality reporting requirements to request reconsideration of FY 2014 payment determinations.

<table>
<thead>
<tr>
<th>Current Quality Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Collection</strong></td>
</tr>
<tr>
<td>1/1/2013 – 12/31/2013</td>
</tr>
</tbody>
</table>
## Proposed Quality Reporting Requirements

<table>
<thead>
<tr>
<th>Data Collection</th>
<th>Data Submission</th>
<th>APU Impact</th>
<th>Measure Name</th>
</tr>
</thead>
</table>
| Hospice Item Set (HIS) 7/1/2014 – 12/31/2014 | Rolling | FY 2016 (10/1/2015) | • Hospice and Palliative Care – Pain Screening, NQF #1634  
• Hospice and Palliative Care – Pain Assessment, NQF #1637  
• Hospice and Palliative Care – Dyspnea Screening, NQF #1639  
• Hospice and Palliative Care – Dyspnea Treatment, NQF #1638  
• Patients Treated with an Opioid who are Given a Bowel Regimen, NQF #1617  
• Hospice and Palliative Care – Treatment Preferences, NQF #1641  
• Beliefs/Values Addressed (if desired by patient), NQF #1647 |

### Update on Hospice Payment Reform Options

CMS provided various updates for several aspects of hospice payment reform. There are no proposals in these updates, but there are discussions of where hospice payment reform might go in the future.

**Reform Options**

CMS contractor, Abt Associates, continues to conduct research and analysis and is developing hospice payment model options. The findings of their research can be found on the [CMS Hospice Center webpage](#).

**Among the options under consideration**
a. U-shaped model of resource use
   ▪ Considering a tiered approach with payment tiers based on length of stay.
     One example: 25% of beneficiaries had stays of 5 days or less
   ▪ Payment for longer periods of service could be made under a tier based on the U-shaped payment model
b. Short-stay add-on payment
   ▪ Could improve payment accuracy
   ▪ Somewhat like home health Low Utilization Payment Amount (LUPA)
c. Case-mix
   ▪ Consider this option as more accurate diagnosis data is gathered

Rebasing the Routine Home Care Rate
CMS is updating the review of the routine home care (RHC) rate and is not including any proposals to rebase the rates at this time. One option is to rebase the RHC rate, based on nine different components of cost originally published in the 1983 Medicare Hospice Conditions of Participation final rule, and then recalculating the rates based on more current data. Analysis has shown evidence of a potential misalignment between the current RHC payment rate and the cost of providing RHC.

<table>
<thead>
<tr>
<th>Routine Home Care Components</th>
<th>1983 Cost per Day</th>
<th>Inflation Factor</th>
<th>FY2011 Cost per Day</th>
<th>Example of rates for FY2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Care</td>
<td>$16.25</td>
<td>N/A</td>
<td>$56.54</td>
<td>$60.83</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>$12.74</td>
<td>N/A</td>
<td>$19.24</td>
<td>$20.70</td>
</tr>
<tr>
<td>Social Services/Therapy</td>
<td>$3.23</td>
<td>N/A</td>
<td>$10.29</td>
<td>$11.07</td>
</tr>
<tr>
<td>Home respite</td>
<td>$1.46</td>
<td>X 3.1704</td>
<td>$4.63</td>
<td>$4.98</td>
</tr>
<tr>
<td>Interdisciplinary group</td>
<td>$2.78</td>
<td>X 3.1704</td>
<td>$8.81</td>
<td>$9.48</td>
</tr>
<tr>
<td>Drugs</td>
<td>$2.78</td>
<td>X 3.1704</td>
<td>$3.74</td>
<td>$4.02</td>
</tr>
<tr>
<td>Supplies</td>
<td>$4.49</td>
<td>X 3.1704</td>
<td>$14.23</td>
<td>$15.31</td>
</tr>
<tr>
<td>Equipment</td>
<td>$1.13</td>
<td>X 3.1704</td>
<td>$3.58</td>
<td>$3.85</td>
</tr>
<tr>
<td>Outpatient Hospital Therapies</td>
<td>$2.99</td>
<td>X 3.1704</td>
<td>$9.48</td>
<td>$10.20</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$46.25</td>
<td></td>
<td>$130.54</td>
<td>$140.44</td>
</tr>
</tbody>
</table>

Site of Service Adjustment for Hospice Patients in Nursing Facilities
CMS has begun analysis of hospice patients in nursing facilities, based on claims data, visit and visit intensity data, and Q code identifiers. CMS is NOT proposing to make a site of service adjustment to reduce payments for RHC patients in nursing facilities, at this time.
1. **Growth:** OIG cited growth of hospice services in nursing facilities, where data shows that beneficiaries often receive longer but less complex care. (July 2011, OIG Report “Medicare Hospices that Focus on Nursing Facility Residents.)

2. **Efficiencies and Workload:** MedPAC cites two concerns in March 2013 MedPAC Report to Congress
   a. Possible efficiencies in the nursing home setting (multiple patients in a single setting, reduced driving time and mileage)
   b. Reduced workload due to an overlap in aide services and supplies provided by the nursing facility.

3. **Higher aide visits:** The number and duration of aide visits for patients in nursing homes is higher than for RHC patients in their own homes. CMS reminded providers of the Medicare Conditions of Participation requirement that hospices provide services at the same level and to the same extent as those services would be provided if the NF/SNF resident were in his or her own home. [Medicare Conditions of Participation 42 CFR 418.112(c)(5)]

**Cost Report Analysis**

1. **Total cost per election period** has not increased from 2007 to 2010
2. **Inpatient costs:** 33% of providers report NO inpatient costs.
3. **Bereavement costs:** 26% of hospice cost reports showed no bereavement costs, even though bereavement services are required by statute.

**Additional Data Collection**

In January 2013, CMS received comments regarding additional data collection efforts to inform hospice payment reform. They are considering the input as they plan for implementing any new data collection, and expect any change to be issued as a change request (CR) this spring or summer.

**Cost Report Changes**

On Monday, April 29, 2013, CMS posted a Paperwork Reduction Act announcement for revisions to the hospice cost report. Those revisions fall under separate rulemaking and have specific comment period deadlines. NHPCO will provide a separate analysis of these changes.