CMS-1449-P
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS-1449-P]

RIN 0938-AR64

Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform.

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the hospice payment rates and the wage index for fiscal year (FY) 2014, and 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 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.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **[OFR--insert date 60 days after date of display in the Federal Register]**.

ADDRESSES: In commenting, please refer to file code CMS-1449-P. Because of staff

and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please 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-1449-P,

P.O. Box 8010,

Baltimore, MD 21244-8010.

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-1449-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your

written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the

"SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Debra Dean-Whittaker, (410) 786 -0848 for questions regarding the hospice experience of care survey.

Robin Dowell, (410) 786-0060 for questions regarding quality reporting for hospices and collection of information requirements.

Hillary Loeffler, (410) 786-0456 for general questions about hospice payment.

Katherine Lucas, (410) 786-7723 for questions regarding payment reform.

Anjana Patel, (410) 786-2120 for questions regarding the hospice wage index and payment rates.

Kelly Vontran, (410) 786-0332 for questions on diagnosis reporting on hospice claims.

SUPPLEMENTARY INFORMATION:

Wage Index Addenda: In the past, the wage index addenda referred to in the preamble of our proposed and final rules were available in the **Federal Register**. However, the wage index addenda of the annual proposed and final rules will no longer be available in the **Federal Register**. Instead, these addenda will be available only through the internet on the CMS Web site at: (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.) Readers who experience any problems accessing any of the wage index addenda related to the hospice payment rules that are posted on the CMS Web site identified above should contact Anjana Patel at 410-786-2120.

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 Web site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

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Acronyms

Because of the many terms to which we refer by acronym in this proposed rule, we are listing the acronyms used and their corresponding meanings in alphabetical order below:

APU	Annual Payment Update
BBA	Balanced Budget Act of 1997

BNAF	Budget Neutrality Adjustment Factor
BLS	Bureau of Labor Statistics
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBSA	Core-Based Statistical Area
CMS	Centers for Medicare & Medicaid Services
CCW	Chronic Conditions Warehouse
CHC	Continuous Home Care
COPD	Chronic Obstructive Pulmonary Disease
CoPs	Conditions of Participation
CR	Change Request
CVA	Cerebral Vascular Accident
DME	Durable Medical Equipment
FEHC	Family Evaluation of Hospice Care
FY	Fiscal Year
GIP	General Inpatient Care
HIS	Hospice Item Set
HHS	Health and Human Services
HQRP	Hospice Quality Reporting Program
LUPA	Low Utilization Payment Amount
MedPAC	Medicare Payment Advisory Commission
MFP	Multi-factor Productivity
MSA	Metropolitan Statistical Area
NEC	Not Elsewhere Classified

NPI	National Provider Identifier
NQF	National Quality Forum
OACT	Office of the Actuary
OMB	Office of Management and Budget
OIG	Office of Inspector General
PRA	Paperwork Reduction Act
PRRB	Provider Reimbursement Review Board
QAPI	Quality Assessment and Performance Improvement
QRP	Quality Reporting Program
RFA	Regulatory Flexibility Act
RHC	Routine Home Care
SBA	Small Business Administration
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TEP	Technical Expert Panel

I. Executive Summary for this Proposed Rule

A. Purpose

This rule proposes updates to the payment rates for hospice providers for fiscal year (FY) 2014 as required under section 1814 (i) of the Social Security Act (the Act). The proposed updates incorporate the use of updated hospital wage index data, the 5th year of the 7-year Budget Neutrality Adjustment Factor (BNAF) phase-out, and an update to the hospice payment rates by the hospice payment update percentage. Additionally, this proposed rule clarifies diagnosis reporting on hospice claims, provides an update on hospice payment reform and additional data collection requirements, and

proposes changes to the quality reporting requirements for hospice providers.

B. Summary of the Major Provisions

In this rule we propose to update the hospice payment rates for FY 2014 by 1.8 percent as described in section III.C.3. The hospice wage index would be updated with more current wage data and the BNAF will be reduced by an additional 15 percent for a total BNAF reduction of 70 percent as described in section III.C.2. The August 6, 2009 FY 2010 Hospice Wage Index final rule (74 FR 39384) finalized a 10 percent reduced BNAF for FY 2010 as the first year of a 7-year phase-out of the BNAF, to be followed by an additional 15 percent per year reduction in the BNAF in each of the next 6 years. The total BNAF phase-out will be complete by FY 2016. This proposed rule also clarifies diagnosis reporting on hospice claims, especially regarding the use of non-specific symptom diagnoses; provides an update on hospice payment reform and additional data collection requirements; proposes a technical regulations text change; and proposes changes to the hospice quality reporting program.

C. Summary of Costs, Benefits, and Transfers

TABLE **1- TRANSFERS**

Provision Description	Total
FY 2014 Hospice Payment Rate Update	The overall economic impact of this proposed rule is an estimated $180 million in increased payments to hospices.

II. Background

A. Hospice Care

Coping with a life-limiting illness can be an overwhelming experience, physically, emotionally and spiritually, for both the person and his or her family. Recognition that the care needs at end-of-life are different from other health care needs is

a foundation of the Medicare hospice benefit. Hospice is a compassionate care philosophy and practice for those who are terminally ill. It is a holistic approach to treatment that recognizes that the impending death of an individual warrants a change from curative to palliative care. Palliative care means "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. The person beginning hospice care, or his or her representative, needs to understand that his or her illness is no longer responding to medical interventions to cure or slow the progression of disease and then must choose to stop further curative attempts while palliative care continues and intensifies, as needed, for continued symptom management. As we stated in the June 5, 2008 Hospice Conditions of Participation final rule (73 FR 32088), palliative care is an approach that "optimizes quality of life by anticipating, preventing, and treating suffering". The goal of palliative care in hospice is to improve the quality of life of individuals and their families facing the issues associated with life-threatening illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other issues. In addition, palliative care in hospice includes coordinating care services, reducing unnecessary diagnostics or ineffective therapies, and offering ongoing conversations with individuals and their families about changes in the disease and shifts in the plan of care to meet the changing needs with disease progression as the individual approaches the end-of-life.

Medicare hospice care is palliative care for individuals with a prognosis of living 6 months or less if the terminal illness runs its normal course. As generally accepted by the medical community, the term "terminal illness" refers to an advanced and progressively deteriorating illness, and the illness is diagnosed as incurable. When an individual is terminally ill, many health problems are brought on by underlying condition(s), as bodily systems are interdependent. In the June 5, 2008 Hospice Conditions of Participation final rule
(73 FR 32088), we stated "the medical director must consider the primary terminal condition, related diagnoses, current subjective and objective medical findings, current medication and treatment orders, and information about unrelated conditions when considering the initial certification of the terminal illness. " As referenced in our regulations at 42 CFR 418.22(b)(1), to be eligible for Medicare hospice services, the beneficiary's attending physician (if any) and the hospice medical director must certify that the individual is terminally ill, that is, the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course as defined in section 1861(dd)(3)(A) of the Act and further clarified in §418.3. The certification of terminal illness must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms as stated in §418.22(b)(3).

The goal of hospice care is to make the hospice patient as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment. Hospice care uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual

services through the use of a broad spectrum of professional and other caregivers and volunteers. While the goal of hospice care is to allow for the individual to remain in his or her home environment, circumstances during the end-of-life may necessitate short-term inpatient admission to a hospital, skilled nursing facility (SNF), or hospice facility for procedures necessary for pain control or acute or chronic symptom management that cannot be managed in any other setting. These acute hospice care services are to ensure that any new or worsening symptoms are intensively addressed so that the individual can return to his or her home environment under routine hospice care. Short-term, intermittent, inpatient respite services are also available to the family of the hospice patient when needed to relieve the family or other caregivers. Additionally, an individual can receive continuous home care during a period of crisis in which an individual requires primarily continuous nursing care to achieve palliation or management of acute medical symptoms to maintain the individual at home. Continuous home care may be covered on a continuous basis for as much as 24 hours a day and these periods must be predominantly nursing care per our regulations at §418.204. A minimum of 8 hours of care must be furnished on a particular day to qualify for the continuous home care rate (§418.302(e)(4)).

B. History of the Medicare Hospice Benefit

Before the creation of the Medicare hospice benefit, hospice was originally run by volunteers who cared for the dying. During the early development stages of the Medicare Hospice Benefit, hospice advocates, working with legislators, were clear that they wanted a Medicare benefit available that provided all-inclusive care for terminally-ill individuals, provided pain relief and symptom management, and offered the

opportunity to die with dignity in the comfort of one's home rather than in an institutional setting.[1] As stated in the August 22, 1983 proposed rule entitled "Medicare Program; Hospice Care" (48 FR 38146), "the hospice experience in the United States has placed emphasis on home care. It offers physician services, specialized nursing services, and other forms of care in the home to enable the terminally ill individual to remain at home in the company of family and friends as long as possible." The concept of a beneficiary "electing" the hospice benefit and being certified as terminally ill were two key components put into the legislation responsible for the creation of the Medicare hospice benefit (section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), (Pub. L. 97-248)). Section 122 of TEFRA created the Medicare hospice benefit, which was implemented on November 1, 1983 under section 1861(dd) of the Social Security Act (the Act), codified at 42 U.S.C. 1395x(dd), to provide coverage of hospice care for terminally ill Medicare beneficiaries who elected to receive care from a Medicare-certified, hospice. In §418.54(c), our regulations stipulate that the comprehensive hospice assessment must identify the patient's physical, psychosocial, emotional, and spiritual needs related to the terminal illness and related conditions which must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors: the nature and condition causing admission (including the presence or lack of objective data and subjective complaints);

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[1] Connor, Stephen. (2007). Development of Hospice and Palliative Care in the United States. OMEGA. 56(1), p89-99.

complications and risk factors that affect care planning; functional status; imminence of death; and severity of symptoms. 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.[2] Additionally, per the hospice Conditions of Participation at §418.56, hospice must provide all services necessary for the palliation and management of the terminal illness, related conditions and interventions to manage pain and symptoms. Therapy and interventions must be assessed and managed in terms of providing palliation and comfort without undue symptom burden for the hospice patient or family.[3] For example, a hospice patient with lung cancer (the terminal illness) may receive inhalants for shortness of breath (related to the terminal condition). The patient may also suffer from metastatic bone pain (a related condition) and would be treated with opioid analgesics. As a result of the opioid therapy, the patient may suffer from constipation (an associated symptom) and requires a laxative for symptom relief. It is often not a single diagnosis that represents the terminal illness of the patient, but the combined effect of several conditions that makes the patient's condition terminal. We are restating what we communicated in the December 16, 1983

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[2] Harder, PharmD, CGP, Julia. (2012). To Cover or Not To Cover: Guidelines for Covered Medications in Hospice Patients. The Clinician. 7(2), p1-3.

[3] Paolini, DO, Charlotte. (2001). Symptoms Management at End of Life. JAOA. 101(10). p609-615.

Hospice final rule regarding what is related versus unrelated to the terminal illness: "…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.

The fundamental premise upon which the hospice benefit was designed was the "revocation" of traditional curative care and the "election" of hospice care for end-of-life symptom management and maximization of quality of life as stated in the December 16,1983 Hospice final rule (48 FR 56008). After electing hospice care, the patient typically returns to the home from an institutionalized setting or remains in the home, to be surrounded by family and friends, and to prepare emotionally and spiritually for death while receiving expert symptom management and other supportive services. Election of hospice care also includes waiving curative treatment for the terminal prognosis, and instead receiving palliative care to manage pain or symptoms.

The benefit was originally designed to cover hospice care for a finite period of time that roughly corresponded to a life expectancy of 6 months or less. Initially, beneficiaries could receive three election periods: two 90-day periods and one 30-day period. Currently, Medicare beneficiaries can elect hospice care for two 90-day periods and an unlimited number of subsequent 60-day periods; however, the expectation remains that beneficiaries have a life expectancy of 6 months or less if the terminal

illness runs its normal course.

C. Services Covered by the Medicare Hospice Benefit

To be covered under the Medicare hospice benefit, 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 (now called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologics); medical appliances; counseling services (including dietary counseling); short-term inpatient care (including both respite care and procedures necessary for pain control and acute or chronic symptom management) in a hospital, nursing facility, or hospice inpatient facility; 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 hospice benefit must be available, as needed, to

beneficiaries 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 expected hospices to continue to use volunteer services, though these services are not to be reimbursed. The hospice interdisciplinary group should be comprised of paid hospice employees as well as hospice volunteers, as stated in the August 22, 1983 Hospice proposed rule (48 FR 38149). This expectation is in line with the history of hospice and philosophy of holistic, comprehensive, compassionate, end-of-life care.

The National Hospice Study was initiated in 1980 through a grant sponsored by the Robert Wood Johnson and John A. Hartford Foundations and CMS (formerly, the Health Care Financing Administration (HCFA). The study was conducted between October 1980 and March 1983. The study summarized the hospice care philosophy as the following:

- Patient and family know of the terminal condition.
- Further medical treatment and intervention are indicated only on a supportive basis.
- Pain control should be available to patients as needed to prevent rather than to just ameliorate pain.
- Interdisciplinary teamwork is essential in caring for patient and family.
- Family members and friends should be active in providing support during the death and bereavement process.
- Trained volunteers should provide additional support as needed.

In the August 22, 1983 Hospice proposed rule (48 FR 38149) we stated "the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the

voluntary spirit of hospices".

D. 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 (routine home care, continuous home care, inpatient respite care, and general inpatient care) to hospices, based on each day a qualified Medicare beneficiary is under hospice election. This per diem payment is to include all of the services needed to manage the beneficiaries' care, as required by section 1861(dd)(1) of the Act. There has been little change in the hospice payment structure since the benefit's inception. The per diem rate based on level of care was established in 1983, and this payment structure remains today with some adjustments, as noted below:

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 for the following two changes in the methodology concerning updating the daily payment rates: (1) effective January 1, 1990, the daily payment rates for routine home care and other services in included in hospice care were increased to equal 120 percent of the rates in effect on September 30, 1989; and (2) the daily payment rate for routine home care and other services included in hospice care for fiscal years beginning on or after October 1, 1990, were the payment rates in effect during the previous Federal fiscal year increased by the

hospital market basket percentage increase.

2. Balanced Budget Act of 1997

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 updated by a factor equal to the hospital market basket percentage increase, 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 fiscal years will be the hospital market basket percentage increase for the FY. The Social Security Act requires us to use the inpatient hospital market basket to determine hospice payment rates.

3. Hospice Wage Index Final Rule for FY 1998

In the August 8, 1997 FY 1998 Hospice Wage Index final rule (62 FR 42860), we implemented a new methodology for calculating the hospice wage index based on the recommendations of a negotiated rulemaking committee. The original hospice wage index was based on 1981 Bureau of Labor Statistics hospital data and had not been updated since 1983. In 1994, because of disparity in wages from one geographical location to another, the Hospice Wage Index Negotiated Rulemaking Committee was formed to negotiate a new wage index methodology that could be accepted by the industry and the government. This Committee was comprised of representatives from national hospice associations; rural, urban, large and small hospices, and multi-site hospices; consumer groups; and a government representative. The Committee decided that in updating the hospice wage index, aggregate Medicare payments to hospices would remain budget neutral to payments calculated using the 1983 wage index, to cushion the

impact of using a new wage index methodology. To implement this policy, a Budget Neutrality Adjustment Factor (BNAF) would be computed and applied annually to the pre-floor, pre-reclassified hospital wage index when deriving the hospice wage index, subject to a wage index floor.

4. Hospice Wage Index Final Rule for FY 2010

Inpatient hospital pre-floor and pre-reclassified wage index values, as described in the 1997 Hospice Wage Index final rule 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 budget neutrality adjustment factor (BNAF). Starting in FY 2010, a 7-year phase-out of the BNAF began (August 6, 2009 FY 2010 Hospice Wage Index final rule, 74 FR 39384), with a 10 percent reduction in FY 2010, and additional 15 percent reduction for a total of 25 percent in

FY 2011, an additional 15 percent reduction for a total 40 percent in FY 2012, and an additional 15 percent reduction for a total of 55 percent in FY 2013. The phase-out will continue with an additional 15 percent reduction for a total reduction of 70 percent in FY 2014, an additional 15 percent reduction for a total reduction of 85 percent in FY 2015, and an additional 15 percent reduction for complete elimination in FY 2016. Note that the BNAF is an adjustment which increases the hospice wage index value. Therefore the BNAF 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 rates.

5. The Affordable Care Act

Starting with FY 2013 (and in subsequent fiscal years), 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 will be annually reduced by changes in economy-wide productivity, as specified in section 1886(b)(3)(B)(xi)(II) of the Act, as amended by section 3132(a) of the Patient Protection and Affordable Care Act of 2010 (Pub. L 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L 111-152) (the Affordable Care Act)). In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions as specified in section 1814(i)(1)(C)(v) of the Act).

In addition, sections 1814(i)(5)(A) through (C) of the Act, as amended by section 3132(a) of the Affordable Care Act, require hospices to begin submitting quality data, based on measures to be specified by the Secretary, for FY 2014 and subsequent fiscal years. Beginning in FY 2014, hospices which fail to report quality data will have their market basket update reduced by 2 percentage points.

Section 1814(a)(7)(D)(i) of the Act was amended by section 3132 (b)(2)(D)(i) of the Affordable Care Act, and requires, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with an individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification and attest that such visit took place. When implementing this provision, we decided that the 180th-day recertification and subsequent recertifications corresponded to the recertification for a beneficiary's third or subsequent benefit periods (August 4, 2011 FY 2012 Hospice Wage Index final rule (76

FR 47314)).

Further, section 1814(i) of the Act, as amended by section 3132(a) of the Affordable Care Act, authorizes 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 Affordable Care Act would capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determines to be appropriate. The data collected may be used to revise the methodology for determining the payment rates for routine home care 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 are required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. Hospice Wage Index Final Rule for FY 2012

When the Medicare hospice benefit was implemented, the Congress included an aggregate cap on hospice payments, which limits the total aggregate payments any individual hospice provider can receive in a year. The Congress stipulated that a "cap amount" be computed each year. The cap amount was set at $6,500 per beneficiary when first enacted in 1983 and is adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers from March 1984 to March of the cap year (section 1814(i)(2)(B) of the Act). The cap year is defined as the period from November 1st to October 31st. As we stated in the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314), for the 2012 cap year and subsequent cap years, the hospice aggregate cap will be calculated using the patient-

by-patient proportional methodology, within certain limits. We will allow existing hospices the option of having their cap calculated via the original streamlined methodology, also within certain limits. New hospices will have their cap determinations calculated using the patient-by-patient proportional methodology. The patient-by-patient proportional methodology and the streamlined methodology are two different methodologies for counting beneficiaries when calculating the hospice aggregate cap. A detailed explanation of these methods is found in the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314). If a hospice's total Medicare reimbursement for the cap year exceeded the hospice aggregate cap, then the hospice would have to repay the excess back to Medicare.

E. Trends in Medicare Hospice Utilization

Since the implementation of the hospice benefit in 1983, and especially within the last decade, there has been substantial growth in hospice utilization. The number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to over 1.3 million in FY 2012. Similarly, Medicare hospice expenditures have risen from $2.9 billion in FY 2000 to $14.7 billion in FY 2012. Our Office of the Actuary (OACT) projects that hospice expenditures are expected to continue to increase by approximately 8 percent annually, reflecting an increase in the number of Medicare beneficiaries, more beneficiary awareness of the Medicare hospice benefit for end-of-life care, and a growing preference for care provided in home and community-based settings. However, this increased spending is partly due to an increased average lifetime length of stay for beneficiaries, from 54 days in 2000 to 86 days in FY 2010, an increase of 59 percent.

There have also been noted changes in the diagnosis patterns among Medicare hospice enrollees, with a growing percentage of beneficiaries with non-cancer diagnoses. Specifically, there were notable increases between 2002 and 2007 in neurologically-based diagnoses, including various dementia diagnoses. Additionally, there have been significant increases in the use of non-specific, symptom-classified diagnoses, such as "debility" and "adult failure to thrive." In FY 2012, both "debility" and "adult failure to thrive" were in the top five claims-reported hospice diagnoses and were the first and third most common hospice diagnoses, respectively (see table 2 below).

Table 2: The Top Twenty Principal Hospice Diagnoses, FY 2002, FY 2007, FY 2012

Rank	ICD-9/Reported Principal Diagnosis		Total Patients	Percentage
	Year: 2002	**Total Patients= 663,406**		
1	162.9	Lung Cancer	73,769	11%
2	428.0	Congestive Heart Failure	45,951	7%
3	799.3	Debility Unspecified	36,999	6%
4	496	COPD	35,197	5%
5	331.0	Alzheimer's Disease	28,787	4%
6	436	CVA/Stroke	26,897	4%
7	185	Prostate Cancer	20,262	3%
8	783.7	Adult Failure To Thrive	18,304	3%
9	174.9	Breast Cancer	17,812	3%
10	290.0	Senile Dementia, Uncomp.	16,999	3%
11	153.0	Colon Cancer	16,379	2%
12	157.9	Pancreatic Cancer	15,427	2%
13	294.8	Organic Brain Synd Nec	10,394	2%
14	429.9	Heart Disease Unspecified	10,332	2%

15	154.0	Rectosigmoid Colon Cancer	8,956	1%
16	332.0	Parkinson's Disease	8,865	1%
17	586	Renal Failure Unspecified	8,764	1%
18	585	Chronic Renal Failure (End 2005)	8,599	1%
19	183.0	Ovarian Cancer	7,432	1%
20	188.9	Bladder Cancer	6,916	1%
	Year: 2007	**Total Patients= 1,039,099**		
1	799.3	Debility Unspecified	90,150	9%
2	162.9	Lung Cancer	86,954	8%
3	428.0	Congestive Heart Failure	77,836	7%
4	496	COPD	60,815	6%
5	783.7	Adult Failure To Thrive	58,303	6%
6	331.0	Alzheimer's Disease	58,200	6%
7	290.0	Senile Dementia Uncomp.	37,667	4%
8	436	CVA/Stroke	31,800	3%
Rank	**ICD-9/Reported Principal Diagnosis**		**Total Patients**	**Percentage**
	Year: 2007	**Total Patients= 1,039,099**		
9	429.9	Heart Disease Unspecified	22,170	2%
10	185	Prostate Cancer	22,086	2%
11	174.9	Breast Cancer	20,378	2%
12	157.9	Pancreas Unspecified	19,082	2%
13	153.9	Colon Cancer	19,080	2%
Rank	**ICD-9/Reported Principal Diagnosis**		**Total Patients**	**Percentage**
	Year: 2007	**Total Patients= 1,039,099**		
14	294.8	Organic Brain Syndrome NEC	17,697	2%
15	332.0	Parkinson's Disease	16,524	2%
16	294.10	Dementia In Other Diseases w/o Behav. Dist.	15,777	2%
17	586	Renal Failure Unspecified	12,188	1%
18	585.6	End Stage Renal Disease	11,196	1%
19	188.9	Bladder Cancer	8,806	1%
20	183.0	Ovarian Cancer	8,434	1%
	Year: 2012	**Total Patients= 1,328,651**		
1	799.3	Debility Unspecified	161,163	12%
2	162.9	Lung Cancer	89,636	7%
3	783.7	Adult Failure To Thrive	86,467	7%
4	428.0	Congestive Heart Failure	84,333	6%
5	496	COPD	74,786	6%
6	331.0	Alzheimer's Disease	64,199	5%
7	290.0	Senile Dementia, Uncomp.	56,234	4%
8	429.9	Heart Disease Unspecified	32,081	2%
9	436	CVA/Stroke	31,987	2%
10	294.10	Dementia In Other Diseases w/o Behavioral Dist.	27,417	2%
11	174.9	Breast Cancer	22,421	2%
12	153.9	Colon Cancer	22,197	2%

13	157.9	Pancreatic Cancer	22,007	2%
14	332.0	Parkinson's Disease	21,183	2%
15	185	Prostate Cancer	21,042	2%
16	294.8	Other Persistent Mental Dis.-classified elsewhere	17,762	1%
17	585. 6	End Stage Renal Disease	17,545	1%
18	518.81	Respiratory Failure	12,962	1%
19	294.11	Dementia In Other Diseases w/ Behavioral Dist.	11,751	1%
20	188.9	Bladder Cancer	10,511	1%

Source: FY 2002, 2007, and 2012 hospice claims data from the Chronic Condition Warehouse (CCW), accessed on February 14 and February 20, 2013.

Note(s): The frequencies shown represent beneficiaries that had a least one claim with the specific ICD-9 code listed as the principal diagnosis. Beneficiaries could be represented multiple times in the results if they have multiple claims during that time period with different principal diagnoses.

III. Provisions of the Proposed Rule

A. Diagnosis Reporting on Hospice Claims

This section is a clarification of existing ICD-9-CM coding guidelines. No proposals are being made in this proposed rule with regards to diagnosis coding. These clarifications are not intended to preclude any clinical judgment in determining a beneficiary's eligibility for hospice services, rather these clarifications are to address current and ongoing diagnosis reporting patterns noted on hospice claims. A beneficiary who elects hospice care and meets our eligibility requirements at §418.20, is admitted to the hospice and receives hospice care *prior* to any claim submission, which occurs at the end of each calendar month while under hospice services, or upon the death or discharge of the beneficiary, whichever occurs first. In the July 27, 2012

FY 2013 Hospice Wage Index notice (77 FR 44247), we provided in-depth information

regarding longstanding, existing ICD-9-CM coding guidelines. We also discussed related versus unrelated diagnosis reporting on claims and clarified 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. Based on analysis of preliminary claims data from the first quarter of FY 2013

(October 1, 2012 through December 31, 2012), 72 percent of providers still only report one diagnosis on the hospice claim. This hospice diagnosis data is comparable to the hospice diagnosis data reported in the July 27, 2012 FY 2013 Hospice Wage Index notice (77 FR 44242), in which we stated that over 77 percent of the hospice claims reported only a principal diagnosis. Therefore, in this year's proposed rule, we are further clarifying the ICD-9-CM coding guidelines and CMS' expectations for diagnosis reporting on the hospice claims in order to ensure the Medicare hospice beneficiaries are receiving the holistic comprehensive hospice services based on the initial and ongoing comprehensive assessment and the individualized hospice plan of care. Eligibility for hospice services is based on meeting the eligibility requirements as stated in §418.20 of our regulations. For beneficiaries eligible for the Medicare hospice benefit, access to hospice care or the continuation of hospice care should not be affected or limited by the following ICD-9-CM coding guidelines for diagnosis reporting on claims.

1. ICD-9-CM Coding Guidelines

As previously reported in Section II.E of this proposed rule there have been noted changes in reported hospice diagnosis patterns with the top reported hospice diagnoses being non-cancer diagnoses. The hospice benefit covers all care for the terminal illness, related conditions, and for the management of pain and symptoms. As noted in the *ICD-*

9-CM Official Guidelines for Coding and Reporting, effective October 1, 2011, available at the CMS website at the CMS website at: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html?redirect=/ICD9ProviderDiagnosticCodes/or on the CDC's website at: http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf, "these coding and reporting guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided with the ICD-9-CM itself. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA)."

Additionally, in our regulations at 45 CFR 162.1002, the Secretary adopted the ICD-9-CM code set, including The Official ICD-9-CM Guidelines for Coding and Reporting. The CMS' Hospice Claims Processing manual (Pub 100-04, chapter 11) requires that hospice claims include other diagnoses "as required by ICD-9-CM Coding Guidelines" available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf . HIPAA, federal regulations, and the Medicare hospice claims processing manual all require that these ICD-9-CM Coding Guidelines be applied to the coding and reporting of diagnoses on hospice claims. Regarding diagnosis reporting on hospice claims, we clarified in our July 27, 2012 FY 2013 Hospice Wage Index notice (77 FR 44247 through 44248) 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.

We are actively collecting and analyzing hospice data for evaluation of hospice

payment reform methodologies as mandated in section 3132(a) of the Affordable Care Act. To adequately account for any clinical complexities a given hospice patient might have as a result of related conditions, these related conditions must be included on the Medicare hospice claim. Some hospice providers already report related additional and coexisting diagnoses on their claims; however, the majority of hospice providers do not report this information. The reporting of only one principal diagnosis does not lend to a comprehensive, holistic, and accurate description of the beneficiaries' end-of-life conditions and may not fully reflect the individualized needs in the individual's required hospice plan of care. As a result, analysis of current claims data does not allow us to appropriately determine whether case-mix adjustment, or other considered methods would or would not be a reasonable approach to, or part of, hospice payment reform. Ongoing hospice data analysis is available on the CMS Hospice Center webpage at: http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

2. Use of Nonspecific, Symptom Diagnoses

As mentioned in section II.E, of this proposed rule, there have been changes in the reported hospice principal diagnoses since the inception of the Medicare hospice benefit. In 1983, the most common reported hospice diagnoses were cancer diagnoses. Over time, and with the advancements in medical technology and interventions, there has been a notable shift in the most commonly reported hospice diagnoses from cancers to non-cancer terminal illnesses, such as "debility" and "adult failure to thrive," which are considered to be nonspecific, symptom diagnoses according to ICD-9-CM Coding Guidelines and are under the ICD-9-CM classification of "Symptoms, Signs and Ill-defined Conditions".

Codes under the classification, "Symptoms, Signs, and Ill-defined Conditions", are not to be used as principal diagnosis when a related definitive diagnosis has been established or confirmed by the provider. "Debility" is medically defined as: an unspecified syndrome characterized by unexplained weight loss, malnutrition, functional decline, multiple chronic conditions contributing to the terminal progression, and increasing frequency of outpatient visits, emergency department visits and/or hospitalizations. "Debility" is associated with multiple primary conditions. The individual diagnosed with "Debility" may have multiple comorbid conditions that individually, may not deem the individual to be terminally ill. However, the collective presence of these multiple comorbid conditions will contribute to the terminal status of the individual. Data analysis using FY 2012 claims data for those beneficiaries with a reported principal hospice diagnosis of "debility," and reported secondary diagnoses, shows that congestive heart failure, coronary artery disease, heart disease, atrial fibrillation, Parkinson's disease, Alzheimer's disease, renal failure, chronic kidney disease, and chronic obstructive pulmonary disease are among the most common secondary diagnoses reported. "Adult Failure to Thrive" is often used interchangeably with "Debility" as a primary hospice diagnosis. Despite the specificity of ICD-9-CM Coding Guidelines, it is unclear as to why these two diagnoses are often used interchangeably. "Adult Failure to Thrive" is defined as undefined weight loss, decreasing anthromorphic measurements, and a Palliative Performance Scale < 40 percent. It is also associated with multiple primary conditions contributing to the physical and functional decline of the individual. Four syndromes known to be individually predictive of adverse outcomes in older adults are repeatedly cited as

prevalent in patients with "adult failure to thrive" impaired physical functioning, malnutrition, depression, and cognitive impairment. Data analysis using FY 2012 claims data for those beneficiaries with a reported principal hospice diagnosis of "adult failure to thrive," and reported secondary diagnoses, shows that pneumonia, cerebral vascular accident (stroke), atrial fibrillation, heart disease, Alzheimer's disease, congestive heart failure, and Parkinson's disease are among the most common secondary diagnoses reported.

By the nature of the clinical criteria of "debility" and "adult failure to thrive", these symptom syndromes are the result of *multiple* primary conditions that contribute to the terminal decline. If any or all of these multiple primary conditions have been or are being treated or managed by a health care provider, or if medications have been prescribed for the patient to treat or manage any or all of these multiple primary conditions, we believe that these conditions meet the criteria of being established and/or confirmed by the beneficiary's health care provider and, thus, "debility" or "adult failure to thrive" would not be listed as the principal hospice diagnosis per ICD-9-CM coding guidelines.

Moreover, at the initial hospice election period, an eligible Medicare beneficiary must be certified as terminally ill. This certification is based on the recommendation of the medical director in consultation with, or with input from, the beneficiary's attending physician (if any) and a comprehensive assessment of all body systems. Per our regulations at §418.25, Admission to Hospice Care, "in reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

- Diagnosis of the terminal condition of the patient.
- Other health conditions, whether related or unrelated to the terminal condition.
- Current clinical relevant information supporting all diagnoses."

All physical, emotional, and spiritual issues are assessed and an individualized, specific hospice plan of care is established by the hospice interdisciplinary team. A reported principal hospice diagnosis in the non-specific ICD-9-CM category, "Symptoms, Signs, and Ill-Defined Conditions", such as "debility" or "adult failure to thrive," does not encompass the comprehensive, holistic nature of the assessment and care to be provided under the Medicare hospice benefit. For the eligible Medicare beneficiary who has elected the Medicare hospice benefit, and has been certified as terminally ill per the eligibility criteria, the hospice benefit provides services for all care related to the terminal illness, related conditions, and, for the management of pain and symptoms that result from the terminal illness and related conditions. If a non-specific, ill-defined diagnosis is reported as the principal hospice diagnosis, a comprehensive, individualized patient-centered plan of care, as required, may be difficult to accurately develop and implement, and, as a result, the hospice beneficiary may not receive the full benefit of hospice services. According to the hospice Conditions of Participation at §418.56, "The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

1. Interventions to manage pain and symptoms.

2. A detailed statement of the scope and frequency of services necessary to meet the

specific patient and family needs.

3. Measurable outcomes anticipated from implementing and coordinating the plan of

care.

4. Drugs and treatment necessary to meet the needs of the patient.

5. Medical supplies and appliances to meet the needs of the patient.

6. The interdisciplinary group's documentation of the patient's or representative's level

of understanding, involvement, and agreement with the plan of care, in accordance

with the hospice's own policies, in the clinical record"(42 CFR 418.56(c)).

A comprehensive hospice plan of care starts with accurate and thorough assessment and identification of the conditions contributing to the terminal illness and decline. "Debility" and "adult failure to thrive" are not appropriate principal diagnoses in the terminally ill population as these diagnoses are incongruous to the comprehensive nature of the hospice assessment, the specific, individualized hospice plan of and care, and the hospice services provided. CMS is aware that diagnosing diseases is not always a perfect science but the expectation is that based on the comprehensive hospice assessment, the certifying physicians are using their best clinical judgment in determining the principal diagnosis and related conditions.

In this proposed rule, we would clarify that "debility" and "adult failure to thrive"

would 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, and the claim would be returned to the provider 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. We believe that the private sector requires that ICD-9-CM coding guidelines be followed; this includes not allowing "debility" and "adult failure to thrive" as principal diagnoses on private sector hospice claims. The principal diagnosis listed should be determined by the certifying hospice physician(s) as the diagnosis *most contributory* to the terminal condition. When there are two or more interrelated conditions (such as diseases in the same ICD-9-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise. In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or other coding guidelines do not provide sequencing direction, any one of the diagnoses may be sequenced first. We expect hospice providers to code the most definitive, contributory terminal diagnosis in the principal diagnosis field with all other related conditions in the additional diagnoses fields for hospice claims reporting. As stated previously, these clarifications are not intended to preclude any clinical judgment in determining a beneficiary's eligibility for hospice services. Therefore, CMS does not expect that these coding clarifications will create any limitations or barriers to accessing

Medicare hospice services by eligible Medicare beneficiaries as coding on claims occurs after the beneficiary has elected and accessed hospice services. In fact, adherence to the ICD-9-CM coding guidelines should promote access to appropriate and comprehensive hospice services. We solicit comments regarding these ICD-9-CM coding guideline clarifications.

3. Use of "Mental, Behavioral and Neurodevelopmental Disorders" ICD-9-CM Codes

Another concerning trend noted in the top twenty claims-reported principal hospice diagnoses is the use of codes that fall under the classification of "Mental, Behavioral and Neurodevelopmental Disorders." There are several codes that fall under this classification that encompass multiple dementia diagnoses that are frequently reported principal hospice diagnoses on hospice claims, but are not appropriate principal diagnoses per ICD-9-CM Coding Guidelines. Some of these ICD-9-CM codes are considered manifestation codes. In accordance with the 2012 ICD-9-CM Coding Guidelines, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation." In most cases, these manifestation codes will have in the code title, "in diseases classified elsewhere" or "in conditions classified elsewhere." Codes with this in the title are a component of the etiology/manifestation convention. The codes with "in diseases classified elsewhere" or "in conditions

classified elsewhere" in the title indicates that it is a manifestation code. "In diseases classified elsewhere" or "in conditions classified elsewhere" codes are never permitted to be used as first listed or principal diagnosis codes and they must be listed following the underlying condition.

However, there are manifestation codes that do not have "in diseases classified elsewhere" or "in conditions classified elsewhere" in their title. For such codes a "use additional code" note would still be present, and the rules for coding sequencing still apply. We note that several dementia codes which are not allowable as principal diagnoses per ICD-9-CM coding guidelines are under the classification of "Mental, Behavioral and Neurodevelopmental Disorders." According to the ICD-9-CM coding guidelines for "Mental, Behavioral and Neurodevelopmental Disorders", dementias that fall under this category are "most commonly a secondary manifestation of an underlying causal condition." Data analysis using FY 2012 claims data for those beneficiaries with a reported principal hospice diagnosis of a dementia classified under "Mental, Behavioral and Neurodevelopmental Disorders" and reported secondary diagnoses shows that Alzheimer's disease, Parkinson's disease, and stroke were the among the most common secondary diagnoses reported. Therefore, we are further reiterating the importance of following the ICD-9-CM coding guidelines for diagnosis reporting on the hospice claims submission.

There are, however, other ICD-9-CM dementia codes, such as those for Alzheimer's disease and others that fall under the ICD-9-CM classification, "Diseases of the Nervous System and Sense Organs" which are acceptable as principal diagnoses per ICD-9-CM coding guidelines. However, there are also dementia codes under this

classification that do have manifestation/etiology or sequencing conventions; therefore, 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.

Again, these clarifications are not intended to preclude any clinical judgment in determining a beneficiary's eligibility for hospice services; rather these are clarifications regarding the reporting of dementia diagnoses on the hospice claims. We are restating that CMS expects hospice providers to code the most definitive, contributory terminal illness in the principal diagnosis field with all other related conditions in the additional diagnoses fields for hospice claims reporting. The reporting of accurate diagnoses of the principal terminal condition and all related conditions is keeping with the intent of the comprehensive, holistic nature of the Medicare hospice benefit. By adhering to these comprehensive assessment and diagnostic principals and coding guidelines, CMS expects that there will be no limitations or barriers to access to hospice care by eligible Medicare beneficiaries, and should; in fact, promote appropriate and comprehensive hospice services as per the original intent of the Medicare hospice benefit as proposed and finalized in the 1983 rules. We solicit comments regarding these ICD-9-CM coding guideline clarifications.

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

a. General Rules for Principal Diagnosis

Based on the ICD-9-CM coding guidelines, the circumstances of an inpatient

admission always govern the selection of principal diagnosis. 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." In analyzing frequently reported principal hospice diagnoses, data analysis revealed differences between reported principal hospice diagnoses and reported principal hospital diagnoses in patients who elected hospice within 3 days of discharge from the hospital. In analyzing data on cancer diagnoses of Medicare hospice beneficiaries for 2009 through 2011, Table 3 below shows that beneficiaries with a hospital-reported principal cancer diagnosis that elected hospice within three days of hospital discharge did not always have a hospice-reported principal cancer diagnosis. 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 the principal hospice diagnosis following a hospice beneficiary's inpatient hospitalization. It is unclear as to why there is this discrepancy in the hospital/hospice diagnosis patterns as ICD-9-CM Coding Guidelines are specific regarding principal diagnosis selection.

Table 3: Principal Hospice Diagnoses and Incidence of Same Diagnoses from Hospitalizations within Three Days Prior to Hospice Election, FY 2009-2011

ICD-9 Diagnoses		**Instances of Principal Hospital Diagnosis…**	**…That Then Also Became Hospice Principal Diagnosis**	
Label	*ICD-9 Code Ranges*	#	#	*% of Total Instances of Principal Hospital Diagnosis*
Lung & Chest Cavity Cancer	162-165s	32,428	27,939	86.2%
Colo-Rectal Cancer	153-154s	10,360	8,270	79.8%
Blood & Lymphatic Cancer	200-208s	15,491	12,747	82.3%
Breast Cancer	174-175s	1,881	1,651	87.8%
Pancreatic Cancer	157s	11,334	9,887	87.2%
Prostate Cancer	185s	1,764	1,520	86.2%
Liver Cancer	155-156s	6,710	5,009	74.6%
Bladder Cancer	188s	2,844	2,218	78.0%

Source: FY 2009-2011 Hospice claims matched with hospital inpatient claims where no more than three days passed between hospital discharge and hospice admission.

Note(s): Data sources included the Hospice Claims File (FYs 2009-2011) and the Hospitalizations File (FY 2009 through 2011). These two files were combined and records utilized for analysis were trimmed where Hospital Beneficiary ID equaled Hospice Beneficiary ID and Hospice Admit Date was within three days of Hospital Discharge Date. The data included the beneficiaries' ID number, their hospice admission date, the ICD-9 code for their principal hospice diagnosis, the hospital discharge date, and the ICD-9 code for their admitting hospital diagnosis.

Further, 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.

b. General Rules for Other (Additional) Diagnoses

For reporting purposes the definition for "other diagnoses" is interpreted as *additional* conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or

- increased nursing care and/or monitoring.

The UHDDS item #11-b 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". Section IV.K of the ICD-9-CM Coding Guidelines addresses outpatient settings, and instructs providers to "code all documented conditions at the time of the encounter/visit, and require or affect patient care treatment or management." These guidelines for determining principal and other diagnoses are stated in the ICD-9-CM Coding Guidelines.

We do not believe that requiring the reporting of other, additional, and/or coexisting diagnoses that are related to the terminal illness and related conditions would create a clinical or administrative burden on hospices. We note that some hospice providers are already reporting these diagnoses on their claims. Information on a patient's related and unrelated diagnoses should already be included as part of the hospice comprehensive assessment and appropriate interventions for the palliation and management of the terminal illness and related conditions should be incorporated into the patient's plan of care, as determined by the hospice interdisciplinary group (IDG). The hospice Conditions of Participation (CoPs) at §418.54(c)(2) require that the comprehensive assessment "include complications and risk factors that affect care planning." The CoPs at §418.56(e)(4) require that the hospice IDG "provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions." It is common for hospices to include the related and unrelated diagnoses on the comprehensive assessment in order to assure coordinated, holistic, patient care and to monitor the effectiveness of

the care that is delivered.

With the specificity of both the ICD-9-CM coding guidelines and the ICD-10-CM coding guidelines, it is expected 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. This accurate coding of the principal hospice diagnosis and the other, additional, and/or coexisting diagnoses is in keeping with the comprehensive assessment and incorporated into the individualized hospice plan of care to aid hospices in identifying and meeting the hospice beneficiaries' needs. 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.

5. Transition to ICD-10-CM

We note that ICD-10-CM will replace the ICD-9-CM on October 1, 2014. We would apply the coding clarifications discussed above to the ICD-10-CM coding guidelines, as well as the ICD-9-CM guidelines. 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. The term "crosswalking" is generally defined as the act of mapping or translating a code in one code set to a code or codes in another code set. (The terms "crosswalking" and "mapping" are sometimes used interchangeably.) 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. The National

Center for Health Statistics (NCHS) has developed what is known as a "General Equivalence Mappings" (GEMs) for the diagnosis codes. Likewise, we have developed the GEMs for the procedure codes. The GEMs are considered to be the authoritative source for crosswalking between ICD-10 and ICD-9. The GEMs are data files that list the ICD-9 and ICD-10 codes and the attributes of the mapping between the two code sets. There is a file for mapping from ICD-10 to ICD-9 and another for mapping from ICD-9 to ICD-10. The GEMs files are available for free and can be downloaded from the NCHS website, www.cdc.gov/nchs/icd/icd10cm.htm. Hospices should not substitute crosswalking for learning and fully implementing ICD-10-CM into their procedures. Additional information regarding the transition to ICD-10-CM is available through the CMS website at: http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10 and ICD-10-CM coding guidelines can be found on the CDC's website at www.cdc.gov/nchs/data/icd10/10cmguidelines2012.pdf.

B. Proposed Update to the Hospice Quality Reporting Program

1. Background and Statutory Authority

Section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices. 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. Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points could result in the annual market basket update being less than 0.0 percent for a FY and may result in

payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the particular FY involved. Any such reduction would not be cumulative or be taken into account in computing the payment amount for subsequent FYs.

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form, manner, and at a time specified by the Secretary. Any measures selected by the Secretary must have been endorsed by the consensus-based entity which holds a contract regarding performance measurement with the Secretary under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). However, section 1814(i)(5)(D)(ii) of the Act provides that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus-based entity, the Secretary may specify measures that are not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary. Section 1814(i)(5)(D)(iii) of the Act requires that the Secretary publish selected measures applicable with respect to FY 2014 no later than October 1, 2012.

2. Quality Measures for Hospice Quality Reporting Program and Data Submission Requirements for Payment Year FY 2014

The successful development of a Hospice Quality Reporting Program (HQRP) that promotes the delivery of high quality healthcare services is our paramount concern. We seek to adopt measures for the HQRP that promote efficient and safer care. Our

measure selection activities for the HQRP takes into consideration input we receive from the Measure Applications Partnership (MAP), convened by the National Quality Forum (NQF), as part of a pre-rulemaking process that we have established and are required to follow under section 1890A of the Act. The MAP is a public-private partnership comprised of multi-stakeholder groups convened by the NQF for the primary purpose of providing input to CMS on the selection of certain categories of quality and efficiency measures, as required by section 1890A(a)(3) of the Act. By February 1st of each year, the NQF must provide that input to CMS. Input from the MAP is located at: (http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx). For more details about the pre-rulemaking process, see the FY 2013 IPPS/LTCH PPS final rule (77 FR at 53376(August 31, 2012)).

We also take into account national priorities, such as those established by the National Priorities Partnership at (http://www.qualityforum.org/npp/), the HHS Strategic Plan http://www.hhs.gov/secretary/about/priorities/priorities.html), and the National Strategy for Quality Improvement in Healthcare located at (http://www.healthcare.gov/news/reports/nationalqualitystrategy032011.pdf).
To the extent practicable, we have sought to adopt measures that have been endorsed by the national consensus organization, recommended by multi-stakeholder organizations, and developed with the input of providers, purchasers/payers, and other stakeholders.

As stated in the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47302, 47320), to meet the quality reporting requirements for hospices for the FY 2014 payment determination as set forth in section 1814(i)(5) of the Act, we finalized the requirement that hospices report two measures:

- An NQF-endorsed measure that is related to pain management, NQF #0209. The data collection period for this measure was October 1, 2012 through December 31, 2012, and the data submission deadline was April 1, 2013. The data for this measure are collected at the patient level, but are reported in the aggregate for all patients cared for within the reporting period, regardless of payer.
- A structural measure that is not endorsed by NQF: Participation in a Quality Assessment and Performance Improvement (QAPI) program that includes at least three quality indicators related to patient care. The data collection period for this measure was October 1, 2012 through December 31, 2012, and the data submission deadline was January 31, 2013. Hospices are not asked to report their level of performance on these patient care related indicators.

Hospices failing to report quality data before the specified deadline in 2013, would have their market basket update reduced by 2 percentage points in FY 2014. Hospice programs would be evaluated for purposes of the quality reporting program based on whether or not they submit data, not based on their performance level on required measures.

For the FY 2014 payment determination, hospices were asked to provide identifying information, and then complete a web based data entry for the required measures. For hospices that could not complete the web based data entry, a downloadable data entry form was made available upon request. Electronic data submission would be required for the FY 2015 payment determination and beyond; there

would be no other data submission method available.

3. Quality Measures for Hospice Quality Reporting Program and Data Submission Requirements for Payment Year FY 2015 and Beyond

In the November 8, 2012 CY 2013 Home Health Prospective Payment System Rate Update final rule (77 FR 67068, 67133), to meet the quality reporting requirements for hospices for the FY 2015 payment determination and each subsequent year, as set forth in section 1814(i)(5) of the Act, we finalized the requirement that hospices report two measures:

- The NQF-endorsed measure that is related to pain management, NQF #0209
- The structural measure: Participation in a Quality Assessment and Performance Improvement (QAPI) Program that includes at least three quality indicators related to patient care. We did not extend the requirement that hospices complete a check list of their patient care indicators and indicate the data sources they used for their quality indicators.

In this rule, we propose that the structural measure related to QAPI indicators and the NQF #0209 pain measure would not be required for the hospice quality reporting program beyond data submission for the FY 2015 payment determination. The original intent of the structural measure was for hospices to submit information about number, type, and data source of quality indicators used as a part of their QAPI Program. Data gathered as part of the structural measure were used to ascertain the breadth and context of existing hospice QAPI programs to inform future measure development activities including the data collection approach for the first year of required reporting (FY 2014). To date, hospices have reported two cycles worth of structural measure data to CMS:

- Voluntary reporting period (submitted to CMS by January 31, 2012) – For the voluntary reporting period hospices submitted free text data describing each quality indicator in their QAPI programs; data regarding number and data source of quality indicators were also submitted.
- FY 2014 (submitted to CMS by January 31, 2013) – For the FY 2014 cycle, hospices submitted data about the topic areas of care addressed by quality indicators in their QAPI Programs, using a drop-down menu checklist rather than free text to reduce burden. Data regarding number and data source of quality indicators were also submitted.

CMS has analyzed data from both reporting periods. Findings from the voluntary reporting period showed that hospices use quality indicators that address a wide range of patient care related topics and that there is great variation in how hospices collect and use "standardized" quality indicators. The majority of reported indicators addressed patient safety and physical symptom management. Likewise, findings from analysis of the FY 2014 structural measure data reiterated findings from the voluntary reporting period.

Other topics addressed included management of psychosocial aspects of care, bereavement and grief, communication, and care coordination. Overall, findings from both data collections of the structural measure have provided adequate information on hospice's patient care-related indicators making further reporting on the structural measure unnecessary.

In addition, we have determined that the NQF # 0209 measure as it is currently collected and reported by hospices is not suitable for long term use as part of the Hospice Quality Reporting Program (HQRP). In making this decision, we considered findings

from the Voluntary Reporting Period and the Hospice Item Set pilot. We will also examine data from the first year of reporting on the measure (impacting FY 2014 APU determination). In addition, we considered stakeholder input including comments submitted during rulemaking, expert input from a Technical Expert Panel (TEP), and provider questions and comments submitted to the hospice quality help desk during the 2012/2013 data collection and reporting period. There are two central concerns with the NQF #0209 measure. First, the measure does not easily correspond with the clinical processes for pain management, resulting in variance in what hospices collect, aggregate, and report. This concern could potentially be addressed by extensive and ongoing provider training or standardizing data collection. However, even with extensive training and the use of a standardized item set during the pilot test, the data showed continued variance in implementation of the measure. Second, there is a high rate of patient exclusion due to patient ineligibility for the measure and patients' denying pain at the initial assessment. This high rate of patient exclusion from the measure results in a small denominator and creates validity concerns. These concerns cannot be addressed by training or standardizing data collection. We recognize the value of measuring hospices' ability to achieve patient comfort and the desire to include a patient outcome measure such as the NQF #0209 in the HQRP. By removing the requirement that hospices submit the NQF #0209 measure, pain comfort would not be measured as part of the HQRP. However, we plan to collect two other measures that reflect care for pain. The standardized item set that CMS has developed contains data elements to collect 7 quality measures endorsed by NQF for hospice. Among these are two process measures related to pain: the NQF #1634, Pain screening, and NQF #1637, pain assessment. However,

while these measures provide insight about screening and assessment of patients, they do not offer information about patient comfort related to pain. An alternative proposal would be to retain NQF #0209 until a more suitable outcome measure was available for use in the HQRP, in order to maintain a focus on achieving patient comfort. We also recognize the importance of adherence to standardized data collection specifications when producing measures for public reporting. We intend to work toward the HQRP's future inclusion of an improved pain outcome measure. We solicit comment on the removal of the checklist and data source questions from the structural measure, and the removal of the NQF #0209 measure. We also solicit comment on the alternative proposal of maintaining NQF #0209 until another pain outcome measure is available.

4. Quality Measures for Hospice Quality Reporting Program for Payment Year FY 2016 and Beyond

As stated in the November 8, 2012 CY 2013 Home Health Prospective Payment System Rate Update final rule (77 FR 67068, 67133), we considered an expansion of the required measures to include additional measures endorsed by NQF. We also stated that to support the standardized collection and calculation of quality measures, collection of the needed data elements would require a standardized data collection instrument. We have 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. We contracted with RTI International to support the development of the Hospice Item Set (HIS) for use as part of the HQRP. In developing the HIS, RTI focused on the NQF endorsed measures that had evidence of use and/or testing with hospice providers. Most of these measures were initially developed during the PEACE (Prepare, Embrace, Attend,

Communicate, and Empower) Project, which was funded by CMS to develop and test an initial set of quality measures for use in hospice and palliative care. The PEACE project, which ended in 2008, resulted in the identification of recommended quality measure and data collection tools that hospice providers could use in their Quality Assessment and Performance Improvement (QAPI) programs to assess quality of care and target areas for improvement. Additional information on the PEACE project can be found at http://www.thecarolinascenter.org/default.aspx?pageid=24.

Most of the measures endorsed by NQF are already widely in use by hospices nationwide as part of their internal Quality Reporting and Performance Improvement (QAPI) programs. Data we received from hospices during the Voluntary Reporting Period in 2011 showed that hospices had implemented and were using the PEACE measures. Some of the PEACE measures were endorsed by NQF in February, 2012, and are listed below with their NQF endorsement numbers. The HIS standardizes the collection of the data elements that are needed to calculate seven of the NQF endorsed measures. The HIS was pilot tested during the early summer of 2012. The primary objective of the pilot was to explore data collection methods and the feasibility of implementing a patient-level item set for possible future use as part of the HQRP.

In developing the standardized HIS, we considered comments offered in response to the July 13, 2012 CY 2013 Home Health Prospective Payment System Rate Update proposed rule (77 FR 41548, 41573). We have included data items that support the following NQF endorsed measures for hospice:

- 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)

To achieve a comprehensive set of hospice quality measures available for widespread use for quality improvement and informed decision making, and to carry out our commitment to develop a quality reporting program for hospices that uses standardized methods to collect data needed to calculate quality measures, we propose the implementation of the HIS in July 2014. We believe that to support the standardized collection and calculation of any or all of the hospice quality measures listed above, it is necessary to use a standardized data collection mechanism. The HIS was developed specifically for this data collection purpose. We expect the HIS Paperwork Reduction Act (PRA) package to post on or within several days after the publication of this FY 2014 Hospice proposed rule. The HIS will be posted on the Paperwork Reduction Act (PRA) area of the CMS.gov website at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/index.html.

We propose that hospices begin the use and submission of the HIS in July 2014. To meet the quality reporting requirements for hospices for the FY 2016 payment determination and each subsequent year, we propose regular and ongoing electronic submission of the HIS data for each patient admitted to hospice on or after July 1, 2014, regardless of payer. Hospices would be required to complete and submit an admission HIS and a discharge HIS for each patient. Hospices failing to report quality data via the

HIS in 2014 would have their market basket update reduced by 2 percentage points in FY 2016. 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 required measures. If our proposals for use of the Hospice Item Set are finalized, we plan to provide Hospices with further information and details about use of the Hospice Item Set. We will provide this information through venues such as postings on the Hospice Quality Reporting Program webpage, Special Open Door Forums, announcements in the CMS E-News, providers training, and National Provider calls. Electronic data submission would be required for HIS submission in CY 2014 and beyond; there would be no other data submission method available. We would make available submission software for the HIS to hospices at no cost. We would also provide reports to individual hospices on their performance on the measures calculated from data submitted via the HIS. The specifics of the reporting system and precisely when specific measures would be made available have not yet been determined. We would report to providers on the following measures on a schedule to be determined:

- 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)

Table 4. Summary Tables:

Finalized in the CY 2013 HH PPS Final Rule			
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 NQF #0209

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

As stated in the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47302, 47320), we finalized that all hospice quality reporting periods subsequent to that for Payment Year FY 2014 would be based on a CY instead of a calendar quarter and for FY 2015 and beyond, the data submission deadline would be April 1st of each year. Our proposal to implement the HIS in July 2014 would negate the CY data collection requirement and the April 1st data submission deadline. We would provide details on data collection and submission timing prior to implementation of the HIS in July 2014.

5. Public Availability of Data Submitted

Under section 1814(i)(5)(E) of the Act, the Secretary is required 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 regarding the hospice's respective program before it is made public. In addition, under section 1814(i)(5)(E) of the Act, the Secretary is authorized to report quality measures that relate to services furnished by a hospice on the CMS website. We recognize that public reporting of quality data is a vital component of a robust quality reporting program and are fully committed to developing the necessary systems for public reporting of hospice quality data. We also recognize it is essential that the data made available to the public be meaningful and that comparing performance between hospices requires that measures be constructed from data collected in a standardized and uniform manner. The development and implementation of a standardized data set for hospices must precede public reporting of hospice quality measures. Once hospices have implemented the standardized data collection approach, we will have the data needed to establish the scientific soundness of the quality measures that can be calculated using the standardized data collection. It is critical to establish the reliability and validity of the measures prior to public reporting in order to demonstrate the ability of the measures to distinguish between the quality of services provided. To establish reliability and validity of the quality measures, at least four quarters of data will need to be analyzed. Typically the first two quarters of data reflect the learning curve of the providers as they adopt a standardized data collection; these data are not used to establish reliability and validity. This means that if the proposal to begin data collection in CY 2014 (Q3) is finalized, the data from CY 2014 (Q3, Q4) would not be used for assessing validity and reliability of the quality measures. Data collected by hospices during CY 2015 would be analyzed

starting in CY 2015. Decisions about whether to report some or all of the quality measures publicly would be based on the findings of analysis of the CY 2015 data. In addition, as noted, the Affordable Care Act requires that reporting be made public on a CMS website and that providers have an opportunity to review their data prior to public reporting. CMS will develop the infrastructure for public reporting, and provide hospices an opportunity to review their data. In light of all the steps required prior to data being publicly reported, we anticipate that public reporting will not be implemented in FY 2016. Public reporting may occur during the FY 2018 APU year, allowing ample time for data analysis, review of measures' appropriateness for use for public reporting, and allowing hospices the required time to review their own data prior to public reporting. We will announce the timeline for public reporting of data in future rulemaking. We welcome public comment on what we should consider when developing future proposals related to public reporting.

6. Proposed Adoption of the CMS Hospice Experience of Care Survey for the FY 2017 Payment Determination and that of Subsequent Fiscal Years

In the CY 2013 Home Health Prospective Payment System Rate Update final rule (77 FR 67135), we stated that were considering the use of a patient/family experience of care survey in addition to other hospice quality of care (clinical) measures. We are currently developing a Hospice Experience of Care Survey questionnaire drawing heavily on questionnaires in the public domain such as the Family Evaluation of Hospice Care (FEHC). The Hospice Experience of Care Survey would treat the dying patient and his or her informal caregivers (family members or friends) as the unit of care.

Before the development of this survey, there was no official national standard experience of care survey that included standard survey administration protocols. This is one reason we did not adopt the FEHC as our experience of care survey. In addition, topic areas that were not addressed by the FEHC were identified by the public as important to their experiences. The Hospice Experience of Care Survey would include detailed survey administration protocols which would allow for comparisons across hospices. The survey would focus on topics that are important to hospice users and for which informal caregivers are the best source for gathering this information. In addition, the "About You" section of the instrument includes demographic characteristics of the patients and their caregivers which can be used to feed into case mix adjustments of the publicly reported data.

The Hospice Experience of Care Survey now under development would seek information from informal caregivers of patients who died while enrolled in hospices. We plan to field the questionnaires after the patient's death. Fielding timelines would be established to give the respondent some time from the death of their loved one, while simultaneously not delaying so long that the respondent is likely to forget details of the hospice experience. Caregivers would be presented with a set of standardized questions about their own experiences and the experiences of the patient in hospice care. During national implementation of this survey, 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 captures such topics as hospice provider communications with patients and family members, hospice provider care, and patient and family member characteristics. The survey would allow the informal caregiver

(family member or friend) to provide an overall rating of the hospice care their patient received, and would ask if they would recommend "this hospice" to others.

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. Therefore, we are--

- Obtaining input from consumers and stakeholders regarding how hospice patients perceive hospice care and what elements in hospice programs are of greatest importance to patients and informal caregivers.
- Drafting a version of the hospice questionnaire that would be cognitively tested with a small number of respondents in both English and Spanish. This type of testing will allow us to assess how respondents interpret and respond to individual questionnaire items.
- Providing a pilot test of the Hospice Experience of Care Survey instrument after the development of an initial questionnaire is completed. This pilot test would allow us to review survey implementation procedures and use statistical analysis of the survey results to select the final set of questions. In addition, it will allow us to select variables which may be used in the case mix adjustment of survey results for public reporting.

The Hospice Experience of Care Survey, as well as the CAHPS® family of surveys, focuses on patient perspectives on the experience of care, rather than on patient satisfaction. CAHPS® data complements other data, including clinical measures. CAHPS® surveys are specifically intended to focus on issues where the patient (or in this

case the caregiver) is the best source of information. We intend the Hospice Experience of Care Survey to have a similar focus.

We are planning to move forward with a model of survey administration in which we would approve and train survey vendors to administer the survey on behalf of hospices. Hospices would be required to contract with an approved survey vendor and to provide the sampling frame to the approved vendor on a monthly basis. The following are proposed key dates for the national implementation of the Hospice Experience of Care Survey:

- Based on the model of CMS-implemented CAHPS® surveys (that is, Hospital CAHPS® and Home Health Care CAHPS®), we propose that hospices would contract with a CMS-approved survey vendor to conduct a "dry run" of the survey for at least 1 month in the first quarter of CY 2015 (January 2015 through March 2015). Vendors would submit data on the hospice's behalf to the CMS hospice patient experience data center. The deadline for data submission has not yet been finalized. For the "dry run" the survey vendor would follow all the national implementation procedures, but the data would not be publicly reported. The dry run would provide hospices and their vendors with the opportunity to work together under "test" conditions before they are required to start publicly reporting data.

  We propose that hospices would contract with CMS-approved vendors to begin continuous monthly data collection starting April 1, 2015. Data submission dates are being developed; however, we expect that data would be submitted quarterly.

- We propose that the FY 2017 Annual Payment Update (APU) determination, based in part on the Hospice Experience of Care Survey, would include a dry run for at least 1 month in the first quarter of CY 2015 (January 2015, February 2015, and/or March 2015) plus 3 quarters of continuous monthly participation (April 1, 2015 through

  December 31, 2015).
- We propose that subsequent APU determinations would be based upon 4 quarters of continuous monthly participation from January 1 through December 31 of the relevant CY.
- We propose to exempt very small hospices from the survey requirements. Hospices that had fewer than 50 unduplicated or unique deceased patients in the period from January 1, 2014 through December 31, 2014 would be exempt from the Hospice Experience of Care Survey data collection and reporting requirements for the FY 2017 payment determination. The hospices would be required to submit their patient counts for the period of January 1, 2014 through December 31, 2014 to CMS. Data submission procedures would be further specified in future rules. There would be similar exemptions for subsequent APU determinations. However, a hospice would need to submit to CMS their patient count for each future period to qualify for this exemption.

As part of the national implementation, we would develop technical specifications for vendors to follow and would issue a detailed survey guidelines manual prior to the dry run months.

In addition, there would be a web site devoted specifically to the Hospice Survey. It would include information and updates regarding survey implementation and technical assistance. Hospices interested in viewing similar model websites are encouraged to visit the Hospital CAHPS® web site at www.hcahpsonline.org or to the Home Health Care CAHPS® website at https://homehealthcahps.org. On these web sites, viewers can see and download the detailed manuals about the surveys (the Quality Assurance Guidelines for Hospital CAHPS® and the Protocols and Guidelines Manual for Home Health Care CAHPS®), as well as obtain information about the surveys' histories, data submission information, and survey updates.

Consistent with our other implemented surveys, we would provide an email address and toll-free telephone number for technical assistance.

The Affordable Care 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 the FY. Any such reduction would not be cumulative and would not be taken into account in computing the payment amount for subsequent FYs. In the November 8, 2012 CY 2013 Home Health Prospective Payment System final rule (77 FR 67068), it was stated that all hospice quality reporting periods subsequent to that for Payment Year 2014 be based on a CY rather than on a FY. With the proposed dry run timeline of least 1 month in the first quarter of CY 2015 and data collection beginning April 1, 2015, we propose that the survey requirements be part of the Hospice Quality Reporting Program requirements for the FY 2017 payment determination. We are proposing that to meet the FY 2017 requirements, hospices would participate in a dry

run for at least 1 month of the first quarter of CY 2015 (January 2015, February 2015, and/or March 2015) and must collect the survey data on a monthly basis from April 1, 2015 through December 31, 2015.

In summary, we are proposing to start the Hospice Experience of Care Survey requirements with a test run for at least 1 month in the first quarter of CY 2015 with continuous monthly data collection beginning April 1, 2015, to meet the annual payment update requirements for FY 2017. We are proposing to add the Hospice Experience of Care Survey requirements to the Hospice quality reporting program requirements for the FY 2017 annual payment update. Participating hospices would have to contract with an approved Hospice Experience of Care Survey vendor to conduct the survey on their behalf.

7. Notice Pertaining to Reconsiderations Following APU Determinations

At the conclusion of any given quality data reporting period, we would review the data received from each hospice during that reporting period to determine if the hospice has met the reporting requirements. Hospices that are found to be non-compliant with the reporting requirements set forth for that reporting cycle could receive a reduction in the amount of 2 percentage points to their annual payment update for the upcoming payment year.

We are aware that there may be situations when a hospice has evidence to dispute a finding of non-compliance. We further understand that there may be times when a provider may be prevented from submitting quality data due to the occurrence of extraordinary circumstances beyond their control (for example, natural disasters). It is our goal not to penalize hospice providers in these circumstances or to unduly increase

their burden during these times.

Other CMS Quality Reporting Programs, such as Home Health Quality Reporting and Inpatient Quality Reporting, include an opportunity for providers to request a reconsideration pertaining to their APU determinations. We are aware of the potential need for providers to request reconsideration and that we will be making APU determinations for FY 2014 in the coming months. Therefore, to be consistent with other established quality reporting programs, we are using this proposed rule to notify providers of our 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 would be notified of that finding. The purpose of this notification is to put hospices on notice of the following: (1) that they have been identified as being non-compliant with section 3004 of the Affordable Care Act for the reporting cycle in question; (2) that they would be scheduled to receive a reduction in the amount of 2 percentage points to the annual payment update to the applicable fiscal year; (3) that they may file a request for reconsideration if they believe that the finding of non-compliance is erroneous, or that if they were non-compliant, they have a valid and justifiable excuse for this non-compliance; and, (4) that they must follow a defined process on how to file a request for reconsideration, which would be described in the notification.

Upon the conclusion of our review of each request for reconsideration, we would

render a decision. We could reverse our initial finding of non-compliance if: (1) the hospice provides proof of full compliance with the all requirements during the reporting period; or (2) the hospice was not able to comply with requirements during the reporting period, and it provides adequate proof of a valid or justifiable excuse for this non-compliance. We would uphold our initial finding of non-compliance if the hospice could not show any justification for non-compliance.

We would provide details of the reconsideration process, including mechanisms of notification, time frames and mechanisms for filing requests for reconsideration, required content for requests, required supporting documentation, and mechanisms of notification of final determinations on the HQRP section of cms.gov and by program instruction this spring.

C. FY 2014 Rate Update

1. 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 and our regulations at §418.306(c) require each labor market to be established using the most current hospital wage data available, including any changes by the Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions. We have consistently used the pre-floor, pre-reclassified hospital wage index when deriving the hospice wage index. In our August 4, 2005 FY 2006 Hospice Wage Index final rule (70 FR 45130), we began adopting the

revised labor market area definitions as discussed in the OMB Bulletin No. 03-04 (June 6, 2003). This bulletin announced revised definitions for MSAs and the creation of Core-Based Statistical Areas (CBSAs). The bulletin is available online at http://www.whitehouse.gov/omb/bulletins/b03-04.html. In the FY 2006 Hospice Wage Index final rule, we implemented a 1-year transition policy using a 50/50 blend of the CBSA-based wage index values and the MSA-based wage index values for FY 2006. The one-year transition policy ended on September 30, 2006. For FY 2007 and beyond, we have used CBSAs exclusively to calculate wage index values. OMB has published subsequent bulletins regarding CBSA changes. The most recent CBSA changes used for the FY 2014 hospice wage index are found in OMB Bulletin 10-02, available at: http://www.whitehouse.gov/sites/default/files/omb/assets/bulletins/b10-02.pdf.

When adopting OMB's new labor market designations in FY 2006, we identified some geographic areas where there were no hospitals, and thus, no hospital wage index data, which to base the calculation of the hospice wage index. We also adopted the policy that for urban labor markets without a hospital from which 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 these areas in our August 6, 2009 FY 2010 Hospice Wage Index final rule (74 FR 39386). In FY 2014, the only CBSA without a hospital from which hospital wage data could be derived is 25980, Hinesville-Fort Stewart, Georgia.

In our August 31, 2007 FY 2008 Hospice Wage Index final rule (72 FR 50214), we implemented a new methodology to update the hospice wage index for rural areas without a hospital, and thus no hospital wage data. In cases where there was a rural area

without rural hospital wage data, we used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. In our August 31, 2007 FY 2008 Hospice Wage Index final rule, we noted that we interpret the term "contiguous" to mean 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, our policy of imputing a rural pre-floor, pre-reclassified hospital wage index based on the pre-floor, pre-reclassified hospital wage index (or indices) of CBSAs contiguous to a rural area without a hospital from which hospital wage data could be derived does not recognize the unique circumstances of Puerto Rico. While we have not identified an alternative methodology for imputing a pre-floor, pre-reclassified hospital wage index for rural Puerto Rico, we will continue to evaluate the feasibility of using existing hospital wage data and, possibly, wage data from other sources. For FY 2008 through FY 2013, we have used the most recent pre-floor, pre-reclassified hospital wage index available for Puerto Rico, which is 0.4047. In this proposed rule, for FY 2014, we continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

For FY 2014, we would use the 2013 pre-floor, pre-reclassified hospital wage index to derive the applicable wage index values for the hospice wage. We would continue to use the pre-floor, pre-reclassified hospital wage data as a basis to determine the hospice wage index values because hospitals and hospices both compete in the same labor markets, and therefore, experience similar wage-related costs. We believe the use of the pre-floor, pre-reclassified hospital wage index data, as a basis for the hospice wage index, results in the appropriate adjustment to the labor portion of the costs. The FY

2014 hospice wage index values presented in this proposed rule were computed consistent with our pre-floor, pre-reclassified hospital (IPPS) wage index policy (that is, our historical policy of not taking into account IPPS geographic reclassifications in determining payments for hospice). The FY 2013 pre-floor, pre-reclassified hospital wage index does not reflect OMB's new area delineations, based on the 2010 Census, as outlined in OMB Bulletin 13-01, released on February 28, 2013. Moreover, the proposed FY 2014 pre-floor, pre-reclassified hospital wage index does not contain OMB's new area delineations because those changes will be in the FY 2014 IPPS proposed rule, which will be published in the **Federal Register,** in the near future. CMS intends to propose changes to the FY 2015 hospital wage index based on the newest CBSA changes in the FY 2015 IPPS proposed rule. Therefore, if CMS incorporates OMB's new area delineations, based on the 2010 Census, in the FY 2015 hospital wage index, those changes would also be reflected in the FY 2016 hospice wage index.

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

This proposed rule would update the hospice wage index values for FY 2014 using the FY 2013 pre-floor, pre-reclassified hospital wage index. 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 then subject to either a budget neutrality adjustment or application of the hospice floor to compute the hospice wage index used to determine payments to hospices. Pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by either: (1) the hospice budget neutrality adjustment factor (BNAF); or (2)

the hospice floor subject to a maximum wage index value of 0.8; whichever results in the greater value.

The BNAF is calculated by computing estimated payments using the most recent, completed year of hospice claims data. The units (days or hours) from those claims are multiplied by the updated hospice payment rates to calculate estimated payments. For the FY 2014 Hospice Wage Index proposed rule, that means estimating payments for FY 2014 using units (days or hours) from FY 2012 hospice claims data, and applying the FY 2014 hospice payment rates. The FY 2014 hospice wage index values are then applied to the labor portion of the payments. The procedure is repeated using the same units from the claims data and the same payment rates, but using the 1983 Bureau of Labor Statistics (BLS)-based wage index instead of the updated raw pre-floor, pre-reclassified hospital wage index (note that both wage indices include their respective floor adjustments). The total payments are then compared, and the adjustment required to make total payments equal is computed; that adjustment factor is the BNAF.

The August 6, 2009 FY 2010 Hospice Wage Index final rule finalized a provision to phase out the BNAF over 7 years, with a 10 percent reduction in the BNAF in FY 2010, and an additional 15 percent reduction in each of the next 6 years, with complete phase out in FY 2016 (74 FR 39384). Once the BNAF is completely phased out, the hospice floor adjustment would simply consist of increasing any wage index value less than 0.8 by 15 percent, subject to a maximum wage index value of 0.8. Therefore, in accordance with the FY 2010 Hospice Wage final rule, the BNAF for FY 2014 will be reduced by an additional 15 percent for a total BNAF reduction of 70 percent (10 percent

from FY 2010, an additional 15 percent from FY 2011, an additional 15 percent for FY 2012, an additional 15 percent for FY 2013 and an additional 15 percent in FY 2014).

The unreduced BNAF for FY 2014 is 0.061498 (or 6.1498 percent). A 70 percent reduction to the BNAF is computed to be 0.018449 (or 1.8449 percent). For FY 2014, this is mathematically equivalent to taking 30 percent of the unreduced BNAF value, or multiplying 0.061498 by 0.30, which equals 0.018449 (1.8449 percent). The BNAF of 1.8449 percent reflects a 70 percent reduction in the BNAF. The 70 percent reduced BNAF (1.8449 percent) was applied to the pre-floor, pre-reclassified hospital wage index values of 0.8 or greater.

The 10 percent reduced BNAF for FY 2010 was 0.055598, based on a full BNAF of 0.061775; the additional 15 percent reduced BNAF FY 2011 (for a cumulative reduction of 25 percent) was 0.045422, based on a full BNAF of 0.060562; the additional 15 percent reduced BNAF for FY 2012 (for a cumulative reduction of 40 percent) was 0.035156, based on a full BNAF of 0.058593; the additional 15 percent reduced BNAF for FY 2013 (for a cumulative reduction of 55 percent) was 0.027197, based on a full BNAF of 0.060438; and the additional 15 percent reduced BNAF for FY 2014 (for a cumulative reduction of 70 percent) is 0.018449, based on a full BNAF of 0.061498.

Hospital wage index values which are less than 0.8 are subject to the hospice floor calculation. For example, if in FY 2013, County A had a pre-floor, pre-reclassified hospital wage index (raw wage index) value of 0.3994, we would perform the following calculations using the budget-neutrality factor (which for this example is an unreduced BNAF of 0.061498, less 70 percent, or 0.018449) and the hospice floor to determine County A's hospice wage index:

Pre-floor, pre-reclassified hospital wage index value below 0.8 multiplied by 1+ 70 percent reduced BNAF: (0.3994 x 1.018449 = 0.4068); Pre-floor, pre-reclassified hospital wage index value below 0.8 multiplied by 1 + hospice floor: (0.3994 x 1.15 = 0.4593).Based on these calculations, County A's hospice wage index would be 0.4593. The BNAF may be updated for the final rule based on availability of more complete data.

An addendum A and Addendum B with the FY 2014 wage index values for rural and urban areas will not be published in the **Federal Register**. The FY 2014 wage index values for rural areas and urban areas are available via the internet at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html. The hospice wage index for FY 2014 set forth in this proposed rule includes the BNAF reduction and would be effective October 1, 2013 through September 30, 2014.

3. Hospice Payment Update Percentage

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) 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 market basket index, 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 market basket percentage for that FY. The Act requires us to use the inpatient hospital market basket to determine the hospice payment rate update. In addition, section 3401(g) of the Affordable Care Act mandates that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. In addition, section 3401(g) of the

Affordable Care Act also mandates that in FY 2013 through FY 2019, the hospice payment update percentage will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act). 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 Insight, Inc.'s first quarter 2013 forecast with historical data through the fourth quarter of 2012). A detailed description of how the inpatient hospital market basket is derived will be available in the FY 2014 IPPS proposed rule, which will be published in the **Federal Register,** in the near future. Due to the requirements at 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the estimated inpatient hospital market basket update for FY 2014 of 2.5 percent must be reduced by a productivity adjustment as mandated by Affordable Care Act (currently estimated to be 0.4 percentage point for FY 2014). The estimated inpatient hospital market basket for FY 2014 is reduced further by a 0.3 percentage point, as mandated by the Affordable Care Act. In effect, the proposed hospice payment update percentage for FY 2014 is 1.8 percent. We are also proposing that if more recent data are subsequently available (for example, a more recent estimate of the inpatient hospital market basket and productivity adjustment), we would use such data, if appropriate, to determine the FY 2014 market basket update and the multi-factor productivity MFP adjustment in the FY 2014 Hospice PPS final rule.

Currently, the labor portion of the hospice payment rates is as follows: for Routine Home Care, 68.71 percent; for Continuous Home Care, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent. 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 Routine Home Care, 31.29 percent; for Continuous Home Care, 31.29 percent; for General Inpatient Care, 35.99 percent; and for Respite Care, 45.87 percent.

4. Proposed Updated FY 2014 Hospice Payment Rates

Historically, the hospice rate update has been published through a separate administrative instruction issued annually in the summer to provide adequate time to implement system change requirements; however, starting in this FY 2014 rule and for subsequent fiscal years, we propose to use rulemaking as the means to propose hospice payment rates. This change is proposed to be consistent with the rate update process in other Medicare benefits, and should provide rate information to hospices as quickly as, or earlier than, when rates are published in an administrative instruction.

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 routine home care rate for each day the beneficiary is enrolled in hospice, unless the hospice provides continuous home care, inpatient respite care, or general inpatient care. Continuous home care is provided during a period of patient crisis to maintain the patient at home, inpatient respite care is short-term care to allow the usual caregiver to rest, and general inpatient care is to treat symptoms that cannot be managed in another setting.

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 as discussed in section III.C.3. 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.

Table 5: Proposed FY 2014 Hospice Payment Rates Updated by the Proposed Hospice Payment Update Percentage

Code	Description	FY 2013 Payment Rates	Multiply by the FY 2014 proposed hospice payment update of 1.8 percent	FY 2014 Proposed Payment Rate	Labor Share of the proposed payment rate	Non-Labor share of the proposed payment rate
651	Routine Home Care	$153.45	x1.018	$156.21	$107.33	$48.88
652	Continuous Home Care Full Rate = 24 hours of care $=37.99 hourly rate	$895.56	x1.018	$911.68	$626.42	$285.26
655	Inpatient Respite Care	$158.72	x1.018	$161.58	$87.46	$74.12
656	General Inpatient Care	$682.59	x1.018	$694.88	$444.79	$250.09

The Congress required in sections 1814(i)(5)(A) through (C) of the Act that hospices begin submitting quality data, based on measures to be specified by the Secretary. Beginning in FY 2014, hospices which fail to report quality data will have their market basket update reduced by 2 percentage points. In the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47320 through 47324), we implemented a hospice Quality Reporting Program (QRP) 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. Hospices failing to report quality data in 2013 will have their market basket update reduced by 2 percentage points in FY 2014.

Table 6: Proposed FY 2014 Hospice Payment Rates Updated by the Proposed Hospice Payment Update Percentage for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2013 Payment Rates	Multiply by the FY 2014 hospice payment update percentage of 1.8 percent minus 2 percentage points (-0.2)	FY 2014 Proposed Payment Rate
651	Routine Home care	$153.45	x0.998	$153.14
652	Continuous Home Care Full Rate= 24 hours of care $=37.99 hourly rate	$895.56	x0.998	$893.77
655	Inpatient Respite Care	$158.72	x0.998	$158.40
656	General Inpatient Care	$682.59	x0.998	$681.22

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

D. Update on Hospice Payment Reform and Data Collection

In 2010, the Congress amended section 1814(i)(6) of the Act with section 3132(a) of the Affordable Care Act. The amendment authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and for other purposes. The types of data and information described in the Act would capture resource utilization and other measures of cost, which can be collected on claims, cost reports, and possibly other mechanisms as we determine to be appropriate. The data collected may be used to revise the methodology for determining the payment rates for routine home care 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 are required to consult with hospice programs and the Medicare Payment Advisory

Commission (MedPAC) regarding additional data collection and payment revision options.

This section of the proposed rule contains three subsections which update the public or discuss different aspects of hospice payment reform; there are no proposals in any of these three subsections.

1. Update on Reform Options

Our hospice contractor, Abt Associates, continues to conduct research and analyses, to identify potential data collection needs, and to research and develop hospice payment model options. To date, we completed an environmental scan; a draft analytic plan; and convened technical advisory panel meetings under the initial contract with Abt in 2010. We are continuing with these efforts under a contract awarded in September 2011. In June 2012, we convened stakeholder meetings where research findings were presented on potential payment system vulnerabilities; utilization of the Medicare hospice benefit, including general inpatient care use during the period the beneficiary is enrolled in hospice care; analysis of hospice cost reports; and the effects of the face-to-face encounter requirement. These and other findings are described in the Abt Hospice Study Technical Report, which is available on the CMS Hospice Center webpage, at http://www.cms.gov/Center/Provider-Type/Hospice-Center.html.

Additionally, we continue to conduct analyses of various payment reform model options under consideration. These models include a U-shaped model of resource use which MedPAC recommended that we adopt, and which is described in Chapter 6 of its March, 2009 report entitled "Report to the Congress: Medicare Payment Policy" (available online at:

http://www.medpac.gov/chapters/Mar09_Ch06.pdf). MedPAC determined that the level of Medicare payment to a hospice under the current per diem payment system is constant throughout a hospice patient's stay. The report noted that the constancy of the per diem payment over the course of a hospice stay is misaligned with a hospice's costs during the stay. A hospice's costs typically follow a U-shaped curve, with higher costs at the beginning and end of a stay, and lower costs in the middle of the stay. This cost curve reflects hospices' higher service intensity at the time of the patient's admission and the time surrounding the patient's death (MedPAC, page 358). Payment under a U-shaped model would be higher at the beginning and end of a hospice stay, and lower in the middle portion of the stay.

The analysis found that very short hospice stays have a flatter curve than the U-shaped curve seen for longer stays, and that average hospice costs are much higher. These short stays are less U-shaped because there is not a lower-cost middle period between the time of admission and the time of death. As such, we are also considering a tiered approach, with payment tiers based on the length of stay. For example, payment for stays of 5 days or less (which occurred for about 25 percent of hospice beneficiaries in 2011) could be made under a per diem system that accounts for the higher hospice costs, with no variation in the rate based on length of stay as would occur under a U-shaped model. Payment for longer stays, where costs follow more of a U-shape, could be made under a tier based on the U-shaped payment model, where the per diem amount fluctuates depending upon whether the days billed are at the beginning, middle, or end of the stay.

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 if we retain the current per diem system. The LUPA add-on is made for home health patients who require four or fewer visits during the 60-day episode. These home health episodes are paid based on the visits actually furnished during the episode. For LUPA episodes that occur as the only episode or the first episode in a sequence of adjacent home health episodes for a given beneficiary, an increased payment is made to account for the front-loading of costs (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HomeHlthProspaymt.pdf for more information).

Finally, as we collect more accurate diagnosis data, including data on related conditions, we would also evaluate whether case-mix should play a role in determining payments.

a. Rebasing the Routine Home Care (RHC) Rate

We are updating our review of the hospice RHC rate, but are not including any proposals at this time. Rebasing the RHC rate involves using the existing components that make up the rate, and recalculating based on more current data. RHC is the basic level of care under the Hospice benefit, where a beneficiary receives hospice care, but remains at home. With this level of care, hospice providers are reimbursed per day regardless of the volume or intensity of services provided to a beneficiary on any given day. It is anticipated that there will be days when a beneficiary does not require any services, as well as days when a beneficiary requires several visits from the hospice provider.

When the hospice benefit was created in 1983, the RHC base payment rate was set using nine different components of cost from a relatively small set of hospices (n=26) that were participating in a CMS hospice demonstration, as described in the December 16, 1983 Hospice final rule (48 FR 56008). The nine cost components were: nursing care ($16.25); home health aide ($12.74); social services/therapy ($3.23); home respite ($1.46); interdisciplinary group ($2.78); drugs ($1.18); supplies ($4.49); equipment ($1.13); and outpatient hospital therapies ($2.99). The sum of all the components' costs equaled the base payment rate for RHC as stated in that 1983 hospice final rule. The original RHC rate was set at $46.25. In addition to RHC, we also established three other levels of care for hospice care from data obtained from the Medicare hospice demonstration project: Continuous Home Care (CHC), Inpatient Respite Care (IRC) and General Inpatient Care (GIP).

It is CMS' intent to ensure that reimbursement rates under the Hospice benefit align as closely as possible with the average costs hospices incur when efficiently providing covered services to beneficiaries. As we continue to gather and analyze more data for payment reform, we have found evidence of a potential misalignment between the current RHC payment rate and the cost of providing RHC. One potential option to address this misalignment could be to rebase the hospice RHC rate, though we are not proposing to do so at this time, so that the cost categories established in the rate reflect the changes in the utilization of hospice services provided for palliation and management of terminally ill patients. However, we are still evaluating data and are currently not proposing any changes to address the misalignment.

At this time, we do not have the data to support rebasing six of the nine cost components described in the 1983 final rule. Information on the utilization of drugs, supplies, and equipment is not available from hospice claims data, and the corresponding information that is available from cost reports, such as outpatient hospital therapies, is not sufficiently detailed to allow for rebasing. One approach to consider in more closely aligning RHC payments with costs is to rebase the three clinical service components (nursing, home health aide, social services/therapy) that currently comprise 69.7 percent of the RHC rate by calculating the average cost per day, weighted by the number of RHC days, for each of the three components using FY 2011 cost report data matched to FY 2011 claims data. As part of rebasing the RHC rate we would then inflate the 1983 cost per day for each of the six remaining components by a factor of 3.1704, which corresponds to the market basket increases between 1983 and 2011.[4] We note that our cost report analysis thus far found that drug costs over the years have declined, and the other non-labor components are plateauing. A detailed methodology for rebasing the clinical service components of the RHC rate can be found in the Abt Hospice Study Technical Report which is published with this proposed rule at http://www.cms.gov/Center/Provider-Type/Hospice-Center.html.

Using the methodology described above, the rebased amount for FY 2011 would be $130.54 as described in Table 7 below.

Table 7: Comparison of RHC Rate Cost Components from 1983 to FY 2011

RHC components	1983 Final Rule Cost Per Day	Inflation Factor	FY 2011 Cost per Day

[4] The original RHC rate in 1983 was $46.25. The FY 2011 rate for RHC was $146.63. $146.63/46.25 = 3.1704.

Nursing Care	$16.25	N/A	$56.54
Home Health Aide	$12.74	N/A	$19.24
Social Services/Therapy	$3.23	N/A	$10.29
Home respite	$1.46	X 3.1704	$4.63
Interdisciplinary group	$2.78	X 3.1704	$8.81
Drugs	$1.18	X 3.1704	$3.74
Supplies	$4.49	X 3.1704	$14.23
Equipment	$1.13	X 3.1704	$3.58
Outpatient Hospital Therapies	$2.99	X 3.1704	$9.48
Total	$46.25		$130.54

Source: 1983 Final Rule and FY 2011 hospice cost report and claims data.

Note(s): The costs per day for the clinical services components (nursing care, home health aide and social services/therapy) were calculated based on the cost per minute for each discipline using cost report data multiplied by the RHC minutes for each discipline per RHC day from claims data to compute the cost of a discipline per RHC day. The average cost per day across all hospices in our sample was weighted by the number of RHC days. Of the 2,717 FY 2011 hospice cost reports for freestanding and facility-based hospices that were matched to FY 2011 claims data, we excluded: (1) cost reports with period less than 10 months or greater than 14 months; (2) cost reports with missing information or negative reported values for total costs or payments; (3) providers in the highest and lowest percentile (1% and 99%) in costs per days across all levels of care; (4) the top and bottom 5% of provider margin; and (5) providers were excluded if the log payment to cost ratio was greater than the 90th or less than the 10th percentile of this value across all providers plus or minus 1.5 times the range between the 10th and 90th percentiles of this log ratio. The number of hospices remaining in our sample was 2,140 representing 73.1 percent of RHC days in 2011.

For example, if we were to apply the rebased amounts for the clinical services components of RHC to FY 2014, we would inflate the FY 2011 rebased amount to FY 2013 levels. We first inflated the FY 2011 rebased rate by full hospital market basket of 3.0 percent for FY 2012. The FY 2012 rebased rate would be $134.46 ($130.54 x 1.03=$134.46). We then inflated the FY 2012 rebased rate by full hospital market basket of 2.6 percent for FY 2013. The FY 2013 rebased rate would be $137.96 ($134.46 x 1.026= $137.96). Finally, we inflated the rebased FY 2013 rate ($137.96) by applying the proposed hospice payment update percentage of 1.8 percent to calculate a FY 2014 rebased RHC rate. Therefore, the FY 2014 rebased rate would be $140.44, a 10.1 percent reduction in the FY 2014 proposed RHC payment rate of $156.21, or an estimated reduction in payments to hospices of $1.6 billion in FY 2014. Rebasing the clinical

service components of the RHC payment is one of several approaches to hospice payment reform that CMS could consider for revising the RHC payment rate. As outlined in the Affordable Care Act, hospice payment reform must be done in a budget neutral manner. As rebasing would be considered part of hospice payment reform, 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

As part of future hospice payment reform, we are considering an OIG recommendation to reduce payments to Medicare hospices for beneficiaries in nursing facilities who are receiving hospice care. The OIG's July 2011 report entitled "Medicare Hospices that Focus on Nursing Facility Residents," (available at https://oig.hhs.gov/oei/reports/oei-02-10-00070.pdf) studied hospice patients in nursing facilities. This report noted the growth of hospice services provided to beneficiaries in nursing facilities, and discussed hospices that have a high percentage of their beneficiaries in nursing facilities. The OIG's report noted that the current payment structure provides incentives for hospices to seek out beneficiaries in nursing facilities, as these beneficiaries often receive longer but less complex care. The OIG noted that unlike private homes, nursing facilities are staffed with professional caregivers and are often paid by third-party payers, such as Medicaid. These facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit. To lessen this incentive, the OIG recommended that we reduce Medicare payments for hospice care provided in nursing facilities.

In addition, the March 2012 Medicare Payment Advisory Commission (MedPAC) report entitled "Report to Congress: Medicare Payment Policy" noted that hospices with a higher share of their patients in nursing facilities have margins as high as 13.8 percent (pages 302 and 303). MedPAC attributed these higher margins to possible efficiencies in the nursing home setting (multiple patients in a single setting, reduced driving time and mileage), and to reduced workload due to an overlap in aide services and supplies provided by the nursing facility.

In response to both MedPAC's and OIG's concerns about possible duplication of aide services provided both by the hospice and the nursing facility, we conducted an analysis of the number and length of aide visits per day using 2011 hospice claims data. Table 8 below describes the number and length of aide visits for RHC beneficiaries at home (including patients in an assisted living facility) compared to RHC beneficiaries in a NF or SNF.

Table 8. Hospice Routine Home Care Aide Services 2011

	Sites of Service		Difference	
	Home Q5001/2	**NF/SNF Q5003/4**	**NF/SNF - Home**	%
Number of beneficiaries	769,640	302,004	(467,636)	
Total days	58,637,171	22,946,972	(35,690,199)	
Total visits	16,625,635	8,501,366	(8,124,269)	
Total minutes	1,223,254,095	584,825,520	(638,428,575)	
Visits per beneficiary	21.6	28.1	6.5	30.3%
Minutes per visit	73.6	68.8	(4.8)	6.5%
Total visits / day	0.28	0.37	0.09	30.7%
Total minutes / day	20.86	25.49	4.62	22.2%

Source: Abt Associates Hospice Claims Data File, 2011.

Table 8 demonstrates that hospice patients in a NF/SNF receive more visits than patients at home, though the length of those visits is shorter. Average minutes per day shows that RHC patients in a NF/SNF had hospice aide services of longer duration (25.49 minutes) than RHC patients at home (20.86 minutes). The Medicare Conditions of Participation (CoPs) require 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 home. Hospices provide aide services to beneficiaries at home depending on the beneficiaries' needs. It seems reasonable to expect that a beneficiary who has a paid

caregiver (that is, a NF/SNF aide) does not need as many services from the hospice aide, because those services are being provided by the paid caregiver. As described in the June 5, 2008 Hospice Conditions of Participation final rule (73 FR 32095), "[h]ospice care is meant to supplement the care provided by the patient's caregiver." Given the presence of the paid caregiver in the NF/SNF, we would expect that on average, there would be fewer hospice aide services provided to hospice patients in a NF/SNF than to hospice patients at home.

It is not clear why hospice patients in nursing facilities are receiving more minutes per day of aide services than hospice patients at home. We used regression analysis to control for age, gender, diagnosis, length of stay, and provider characteristics (ownership status, base, size, age of hospice, geographic location) when analyzing the visit data. However, we still found that significantly more aide services were provided to NF/SNF patients than to patients at home, even after controlling for patient and provider characteristics.

The June 5, 2008 Hospice Conditions of Participation final rule (73 FR 32088) preamble details the requirements related to aide services provided to hospice patients residing in a nursing facility. These requirements can also be found at §418.112(c)(4) through (5). The CoPs require a written agreement between the hospice and NF/SNF, which specifies that the NF/SNF should continue to provide the aide services that are provided prior to the hospice election, to meet the patient's needs at that same level of care as if the patient were at home. These services include providing 24 hour room and board care, meeting the patient's personal care needs, and to the degree permitted by State law, administering medications or therapies. There should be no reduction of

NF/SNF aide services to a patient in anticipation of a future hospice election, or once the patient (or his/her representative) elects the hospice benefit. As such, hospice patients in nursing facilities should have much, if not most, of their need for aide services provided by the facility's aide. As stated previously, we would expect that, on average, the hospice aide would be providing fewer services to nursing facility patients than to patients at home.

Table 8 suggests that the hospice aide may be replacing the facility aide, rather than supplementing or augmenting the care of the facility aide. Or, as the OIG and MedPAC identified, there could be an overlap in aide services when a hospice beneficiary is in a NF/SNF. It would not be appropriate for the Medicare hospice benefit to subsidize the nursing home benefit by providing aide services that the facility aide should provide. Section 1862(a)(1)(C) of the Social Security Act (the Act) forbids payment for any items or services which are not reasonable and necessary for the palliation and management of the terminal illness. Services which are not needed, or which are duplicative of those to be provided by the facility aide, would not be reasonable and necessary.

At this time, we are not proposing to make a site of service adjustment to reduce payments for RHC patients in a nursing facility. Any reform option considering reduced payments for RHC care provided to hospice patients in a NF or SNF should not result in a reduction in the services that hospice patients in NFs or SNFs receive, but would instead be a shifting of who provides those aide services; some of the services currently provided by the hospice aide would be provided by the facility aide as expected. As such, we do not expect that the quality of care to hospice patients in a NF/SNF would be

diminished. If such a policy were to be proposed and implemented, it would be made in a budget neutral manner as required by the Affordable Care Act. In addition, we would monitor for any unintended consequences.

2. Reform Research Findings

We have conducted a number of analyses to better understand hospice utilization and trends, to identify vulnerabilities in the payment system, and to develop and test models that would more accurately match hospice resource use with Medicare payments. We posted the Abt Hospice Study Technical Report on hospice payment reform on our hospice center webpage, located at: http://www.cms.gov/Center/Provider-Type/Hospice-Center.html. The report summarizes research findings related to resource use and payment system vulnerabilities.

The report also includes a discussion of hospice cost report analyses. Overall, the total cost per election period has not significantly increased from 2007 to 2010, in real dollars. Inpatient costs constitute about 14 percent of hospice costs across freestanding hospice providers that reported inpatient costs. About one-third of providers reported no inpatient costs. It appeared that some providers with no inpatient costs were substituting continuous home care (CHC) for GIP, based on analysis of the proportion of CHC days. Visiting services (for example, direct labor costs for nurses, aides, social workers, counselors, and therapists) account for about two-thirds of hospice costs, and have trended upward from 2004 to 2010. Nursing care, hospice aides, and medical social services comprise 90 percent of visiting service costs.

Other hospice service costs include non-labor costs such as drugs, durable medical equipment (DME), supplies, imaging, patient transportation, and outpatient

services. These types of services represent about 20 to 25 percent of total hospice costs. Drugs, DME, and supplies account for 90 percent of these other hospice services costs. Drug costs have trended downward over time, while medical supply costs have remained steady. Finally, in examining non-reimbursable costs, we found that 26 percent of providers in 2010 showed no bereavement costs on their cost report, even though bereavement services are required by statute; it is unclear if bereavement services were not provided or if bereavement costs were not correctly reported.

The report also describes an analysis of GIP utilization. In 2010 through 2011, a quarter of all hospice beneficiaries had at least one GIP stay, with a quarter of those stays associated with cancer diagnoses. While most GIP stays were 2 days long, the average GIP length of stay was 5.66 days, reflecting a small number of extremely long GIP stays. Sixty-five percent of GIP stays were provided in a hospice inpatient unit. Almost 80 percent of hospices provided at least one GIP day in 2010 through 2011. Hospices that provided GIP tended to be older and larger.

The Abt Hospice Study Technical Report also provides descriptive statistics for all beneficiaries and for 3 major sites of routine home care services. It includes visit data findings, including visits per day, visits per beneficiary, minutes per day, and minutes per beneficiary for key disciplines reported on hospice claims. Additionally, there are several figures which depict the U-shaped curve for key personnel by length of stay. The curves show that resource use tends to follow a U-shaped curve, but one which is higher at the beginning rather than at the end of the hospice stay. There was little evidence that strong differences in the U-shape exist across most subgroups (for example, freestanding vs. provider-based, ownership status, patient diagnosis).

For more detailed information on these findings, and a description of the methods used, see the Abt Hospice Study Technical Report, which is posted on the hospice center webpage (http://www.cms.gov/Center/Provider-Type/Hospice-Center.html). We have also posted a review of pertinent hospice literature as of December 2012 on the hospice center webpage. This should be considered an evolving document, as Abt Associates updates the review periodically. We encourage interested stakeholders to review this update on our progress. We will continue to collaborate with other federal experts regarding hospice payment reform research efforts and to update stakeholders on our progress on hospice payment reform.

3. Additional Data Collection

Over the past several years, MedPAC, the Government Accountability Office (GAO), and the HHS Office of Inspector General (OIG) have also recommended that we collect more comprehensive data in order to better understand the utilization of the Medicare hospice benefit. In December 2012, we posted a document to our Hospice Center webpage (http://www.cms.gov/Center/Provider-Type/Hospice-Center.html) describing additional data collection which we are considering, and noting that cost report revisions are forthcoming. We received 65 comments about the claims data collection items under consideration, which are briefly summarized below.

- Line item visit data, including length of visit in 15-minute increments, for hospice chaplains and counselors providing care to hospice beneficiaries. Commenters were supportive, but suggested we include phone calls by chaplains and counselors, and allow reporting of chaplain time spent officiating or attending beneficiary funerals, as this is part of their service to families. A few suggested

that we have a separate category for Bereavement Counseling to acknowledge this requirement even if it is not subject to reimbursement. Several suggested we define "other counselors."

- Line item visit data, including length of visits in 15-minute increments, for hospice staff providing care to hospice patients receiving GIP in a hospital or nursing facility, but not for hospice patients receiving GIP in a hospice facility. Our suggestion to collect GIP visit data did not include visits by non-hospice staff, and was focused on patients in a hospital or nursing facility only. Therefore, GIP visits to hospice patients in hospice inpatient facilities continue to be reported as weekly totals, without including the length of visits. Commenters were generally supportive, provided the visits were for hospice staff only. Several comments noted that this would be no more difficult than what already occurs when recording visits to patients' homes.
- The National Provider Identifier (NPI) of facilities where hospice patients are receiving care. Most commenters noted that it would not be difficult to get this information and enter it into their systems. A few commenters noted that sometimes patients are in more than one facility type during a claim period, but that there is only space for one NPI on the claim.
- Post-mortem visits on the calendar day of death. Commenters suggested we collect visit data for various timeframes after the time of death, rather than the calendar day of death, since many deaths occur late at night. They suggested we clarify what we mean by time of death (time death actually occurs, or time the death is pronounced). Several commenters suggested we gather post-mortem visit

data regardless of level of care or site of service.

- Any durable medical equipment (DME) provided by the hospice. Some commenters indicated that this would be difficult to collect and record on claims. Many indicated that DME suppliers bill them monthly, and waiting for the DME invoice would cause a delay in submission of their claims. They also noted that it would take a great deal of lead time to set this up with suppliers and software vendors to track DME at the patient level. A few suggested that we use aggregate data on DME costs from the cost reports instead.
- Non-routine supplies provided by the hospice. Most commenters indicated that this would be difficult to collect and record on claims. A number of commenters wrote that their software does not accommodate such reporting, and that it would create an additional burden on clinical staff to track these items. Several mentioned that it would take some lead time to modify existing systems to enable hospices to track and report this information accurately. A few suggested we use aggregate data on non-routine supplies from the cost reports instead.
- Drugs (injectable, non-injectable, and over-the-counter) provided by the hospice. Most commenters indicated that this would be difficult to collect and record on claims. Several asked if injectable drugs include infusion pumps, which is considered DME. Several commenters noted that the hospice staff person is not always the person administering drugs, making tracking more complicated; they suggested focusing on the fills, rather than drugs administered. Some wrote that hospices get their drugs from multiple pharmacies, making reporting more difficult due to inconsistencies in pharmacy billing. Others wrote that their data

systems are not able to track drugs by patient, and suggested that we use aggregate data from the cost reports instead. Some noted that they purchase some drugs in larger quantities, making reporting at the patient level more complicated. A few noted that this could be done, but said that hospices would need lead time to prepare systems to track and report at the patient level. One suggested that we specify what cost structure drug charges should be based upon, such as average wholesale price plus a percentage.

In summary, commenters were largely supportive of our suggestions to collect additional visit and NPI data on claims. Many suggested collecting data on DME, supplies, and drugs from the cost reports, rather than at the patient level. Several commenters reminded us that their primary focus is patient care, and were concerned about the cost of such data collection. We appreciate the comments submitted, and will consider this input as we move forward towards implementing any new data collection for hospices. We expect to issue a change request detailing the upcoming data collection this spring or summer.

Section 3132(a)(1)(C) of the Affordable Care Act also authorizes us to collect more data on hospice cost reports. The revisions to the hospice cost report and its associated instructions will be described in detail in a revision to the information collection request currently approved under OMB control number 0938-0758. As required by the Paperwork Reduction Act, we will publish the both 60-day and 30-day notices with comment periods in the **Federal Register** in the near future. Comments related to cost report revisions should be submitted as instructed in 60-day and 30-day notices that publish in the **Federal Register**.

E. Technical and Clarifying Regulations Text Change

We are proposing to incorporate the following technical change to correct an erroneous cross reference in our regulations text.

Administrative Appeals (§418.311)

A hospice that does not believe its payments have been properly determined may request a review from the intermediary or from the Provider Reimbursement Review Board (PRRB), depending on the amount in controversy. Section 418.311 details the procedures for appealing a payment decision and also refers to 42 CFR part 405, subpart R. The rationale for this appeals process was explained in the August 22, 1983 Hospice proposed rule (48 FR 38146) and finalized in the December 16, 1983 Hospice final rule (48 FR 56008). Hospices are permitted to appeal computation of the payment limit or the amount due to the hospice to the PRRB if the amount in controversy is $10,000 or more.

We propose to make a technical correction in §418.311 to correct an erroneous reference to §405.1874. The published reference to §405.1874 does not exist and was a typographic error. We are correcting this error by changing the referenced §405.1874 to §405.1875-- Administrator review. Section 405.1875 allows for the Administrator, at his or her discretion, to immediately review any decision of the Board as described in the August 22, 1983 proposed and
December 16, 1983 final rules (48 FR 38159, and 48 FR 56019, respectively).

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB)

for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for this section of this document that contains information collection requirements (ICRs).

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary. Under section 1814(i)(5)(D)(iii) of the Act, the Secretary must publish selected measures that will be applicable with respect to FY 2014 not later than October 1, 2012. In implementing the Hospice quality reporting program, we seek to collect measure information with as little burden to the providers as possible and which reflects the full spectrum of quality performance.

We propose to implement a Hospice Experience of Care Survey to reflect the patients' families' and friends' perspectives of care in hospices. The 60-day notice for the field test of the survey was published on April 4, 2013 (78 FR 20323) under CMS-10475 (OCN 0938-New). While we set out the requirements and burden estimates for

the field study, it is too early to set out the requirements and burden estimates for the national implementation of the survey. We anticipate having the final survey instrument in 2014 and setting out the collection of information requirements and burden estimates in the proposed rule for CY 2015. We propose implementation of the survey in 2015.

In the August 4, 2011 FY 2012 Hospice Wage Index final rule (76 FR 47302, 47320), to meet the quality reporting requirements for hospices for the FY 2014 payment determination as set forth in section 1814(i)(5) of the Act, we finalized the requirement that hospices report two measures: (1) An NQF-endorsed measure that is related to pain management, NQF #0209; and (2) a structural measure that is not endorsed by NQF: Participation in a Quality Assessment and Performance Improvement (QAPI) program that includes at least three quality indicators related to patient care. In this rule, we propose that the structural measure related to QAPI indicators and the NQF #0209 pain measure not be required for the hospice quality reporting program beyond data submission for the FY 2015 payment determination.

We are not proposing to adopt any new measures in this proposed rule. However, we are proposing to implement a hospice patient-level data set to be used by all hospices to collect and submit standardized data about each patient admitted to hospice. This Hospice Item Set will be used to support the standardized collection and calculation of quality measures, collection of the requisite data elements. Hospices would be required to complete and submit an admission HIS and a discharge HIS on all patients admitted to hospice starting July 1, 2014 for FY 2016 APU determination. The admission and discharge HIS will collect the standardized data elements needed to calculate 7 NQF endorsed measures for hospice.

Using 2011 Medicare claims data we have estimated that there will be approximately 1,089,719 admissions across all hospices per year and therefore, we would expect that there should be 1,089,719 Hospice Item Sets (consisting of one admission and one discharge assessment per patient), submitted across all hospices yearly. There were 3,742 certified hospices in the U.S. as of October 1, 2012; we estimate that each individual hospice will submit on average 291 Hospice Item Sets annually or 24 Hospice Items Sets per month.

The Hospice Item Set consists of both an admission assessment and a discharge assessment. As noted above, we estimate that there will be 1,089,719 hospice admissions across all hospices per year. Therefore, we expect there to be 2,179,438 Hospice Item Set submissions, (both admission and discharge assessment) submitted across all hospices annually or 181,620 across all hospices monthly. We further estimate that there will be 582 Hospice Item Set submissions by each hospice annually or 49 submissions monthly.

For the Admission Hospice Item Set, we estimate that it will take 14 minutes of time by a clinician such as a Registered Nurse at an hourly wage of $33.23 to abstract data for Admission Hospice Item Set. This would cost the facility approximately $7.75 for each admission assessment.[5] We further estimate that it will take 5 minutes of time by clerical or administrative staff person such as a medical data entry clerk or medical secretary at an hourly wage of $15.59 to upload the Hospice Item Set data into the CMS

[5] 14 minutes of time by a Registered Nurse at $33.23 / 60 minutes per hour = $0.56; $0.56 per one minute x 5 minutes = $7.75

system. This would cost the facility approximately $1.30 per assessment.[6] For the Discharge Hospice Item Set, we estimate that it will take 5 minutes of time by a clinician such as a nurse at an hourly wage of $33.23 to abstract data for Discharge Hospice Item Set. This would cost the facility approximately $2.77. We further estimate that it will take 5 minutes of time by clerical or administrative staff such as a medical data entry clerk or medical secretary at an hourly wage of $15.59 to upload data into the CMS system. This would cost the facility approximately $1.30.

We estimate that the total nursing time required for completion of both the admission and discharge assessments is 19 minutes at a rate of $33.23 per hour. The annualized cost across all Hospices for the nursing/clinical time required to complete both the admission and discharge Hospice Item sets is estimated to be $11,458,528 and the cost to each individual Hospice is estimated to be $3,062.14. The estimated time burden to hospices for a medical data entry clerk to complete the admission and discharge Hospice Item Set assessments is 10 minutes at a rate of $15.59 per hour. The cost for completion of the both the admission and discharge Hospice Item sets by a medical data entry clerk is estimated to be $2,829,401 across all Hospices and $756.12 to each Hospice.

The total combined time burden for completion of the Admission and Discharge Hospice Data Item Sets is estimated to be 29 minutes. The total annualized cost across all hospices is estimated to be $14,287,929. For each individual hospice, this annualized

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[6] 5 minutes of time by a Medical Data Entry Clerk at $15.59 / 60 minutes per hour = $0.265; $0.265 per one minute x 5 minutes = $1.30

cost is estimated to be $3,818.26. The estimated cost for each individual Hospice Item Set submission is $13.11.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, [CMS-1449-P]

Fax: (202) 395 6974; or

Email: OIRA_submission@omb.eop.gov

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 follows §418.306(c) which requires 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 Metropolitan Statistical Areas (MSAs). This rule proposes updates to the hospice payment rates for FY 2014. In

addition, this proposed rule provides background on hospice care, clarifies diagnosis coding on hospice claims, updates the public on the status of hospice payment reform, proposes a technical and clarifying regulatory text change, and proposes changes to the hospice quality reporting program.

B. Overall Impact

The overall impact of this proposed rule is an estimated net increase in Federal 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 (10 percent in FY 2010, and 15 percent per year for FY 2011 through FY 2014). A 70 percent reduced BNAF is computed to be 0.018449 (or 1.8449 percent). The BNAF reduction is part of a 7-year BNAF phase-out that was finalized in in the August 6, 2009 FY 2010 Hospice Wage Index final rule (74 FR 39384), and is not a policy change.

1. Detailed Economic Analysis

Column 4 of Table 9 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. We estimate that the total hospice payments for FY 2014 would decrease by 0.7 percent. This 0.7 percent is the result of a 0.1 percent reduction due to the use of updated wage data ($-20 million), and a

0.6 percent reduction due to the additional 15 percent reduction in the BNAF ($-100 million). This estimate does not take into account the proposed hospice payment update percentage of 1.8 percent (+$300 million) for FY 2014.

Column 5 of Table 9 shows the combined effects of the updated wage data (the 2012 pre-floor, pre-reclassified hospital wage index), the additional 15 percent reduction in the BNAF (for a total BNAF reduction of 70 percent), and the proposed hospice payment update percentage of 1.8 percent. The proposed 1.8 percent hospice payment update percentage is based on a 2.5 percent estimated inpatient hospital market basket update for FY 2014 reduced by a 0.4 percentage point productivity adjustment and by 0.3 percentage point as mandated by the Affordable Care Act. The estimated effect of the 1.8 percent proposed hospice payment update percentage is an increase in payments to hospices of approximately $300 million. Taking into account the 1.8 percent proposed hospice payment update percentage (+$300 million), the use of updated wage data ($-20 million), and the additional 15 percent reduction in the BNAF ($-100 million), it is estimated that hospice payments would increase by $180 million in FY 2014 ($300 million - $20 million -$100 million = $180 million) or 1.1 percent in FY 2014.

a. Effects on Hospices

This section discusses the impact of the projected effects of the hospice wage index and the effects of a proposed 1.8 percent hospice payment update percentage for FY 2014. This proposed rule continues to use the CBSA-based pre-floor, pre-reclassified hospital wage index as a basis for the hospice wage index and continues to use the same policies for treatment of areas (rural and urban) without hospital wage data. The proposed FY 2014 hospice wage index is based upon the 2012 pre-floor, pre-reclassified

hospital wage index and the most complete claims data available (FY 2012) with an additional 15 percent reduction in the BNAF (for a total BNAF reduction of 70 percent).

For the purposes of our impacts, our baseline is estimated FY 2013 payments with a 55 percent BNAF reduction, using the 2011 pre-floor, pre-reclassified hospital wage index. Our first comparison (column 3 of Table 9) compares our baseline to estimated FY 2014 payments (holding payment rates constant) using the updated wage data (2012 pre-floor, pre-reclassified hospital wage index). Consequently, the estimated effects illustrated in column 3 of Table 9 show the distributional effects of the updated wage data only. The effects of using the updated wage data combined with the additional 15 percent reduction in the BNAF are illustrated in column 4 of Table 9.

We have included a comparison of the combined effects of the additional 15 percent BNAF reduction, the updated wage data, and the proposed 1.8 percent hospice payment update percentage for FY 2014 (Table 9, column 5). Presenting these data gives the hospice industry a more complete picture of the effects on their total revenue based on changes to the hospice wage index and the BNAF phase-out as discussed in this proposed rule and the proposed FY 2014 hospice payment update percentage. 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.

TABLE 9: Anticipated Impact on Medicare Hospice Payments of Updating the Pre-floor, Pre-Reclassified Hospital Wage Index Data, Reducing the Budget Neutrality Adjustment Factor (BNAF) by an Additional 15 Percent (for a Total BNAF Reduction of 70 Percent) and Applying a 1.8 Percent

Hospice Payment Update Percentage, Compared to the FY 2013 Hospice Wage Index with a 55 Percent BNAF Reduction

	Number of Hospices (1)	Number of Routine Home Care Days in Thousands (2)	Percent Change in Hospice Payments due to FY2014 Wage Index Change (3)	Percent Change in Hospice Payments due to Wage Index Change, additional 15% Reduction in Budget Neutrality Adjustment (4)	Percent Change in Hospice Payments due to Wage Index Change, additional 15% Reduction in Budget Neutrality Adjustment and Market Basket Update (5)
ALL HOSPICES	3,545	85,390	-0.1%	-0.7%	1.1%
URBAN HOSPICES	2,575	74,784	-0.1%	-0.7%	1.1%
RURAL HOSPICES	970	10,606	-0.2%	-0.6%	1.2%
BY REGION – URBAN:					
NEW ENGLAND	129	2,780	1.0%	0.4%	2.2%
MIDDLE ATLANTIC	247	8,018	0.0%	-0.6%	1.2%
SOUTH ATLANTIC	376	16,441	-0.7%	-1.3%	0.5%
EAST NORTH CENTRAL	334	11,435	0.0%	-0.6%	1.2%
EAST SOUTH CENTRAL	154	4,332	-0.5%	-1.0%	0.8%
WEST NORTH CENTRAL	195	4,627	0.4%	-0.2%	1.6%
WEST SOUTH CENTRAL	514	9,894	-0.4%	-1.0%	0.8%
MOUNTAIN	260	6,545	-0.8%	-1.4%	0.4%
PACIFIC	331	9,432	0.9%	0.3%	2.1%
OUTLYING	35	1,280	0.3%	0.3%	2.1%
BY REGION – RURAL:					
NEW ENGLAND	24	232	-0.7%	-1.4%	0.4%
MIDDLE ATLANTIC	42	563	-0.1%	-0.7%	1.1%
SOUTH ATLANTIC	135	2,358	-0.3%	-0.6%	1.2%
EAST NORTH CENTRAL	137	1,708	0.4%	-0.2%	1.6%
EAST SOUTH CENTRAL	132	1,814	0.1%	0.0%	1.8%
WEST NORTH CENTRAL	182	1,240	-0.9%	-1.3%	0.5%
WEST SOUTH CENTRAL	175	1,537	-0.1%	-0.2%	1.6%
MOUNTAIN	95	665	0.3%	-0.1%	1.7%
PACIFIC	47	473	-2.2%	-2.9%	-1.1%
OUTLYING	1	15	0.0%	0.0%	1.8%
BY SIZE/DAYS:					
0- 3499 DAYS (small)	587	1,021	-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%	1.2%

	Number of Hospices (1)	Number of Routine Home Care Days in Thousands (2)	Percent Change in Hospice Payments due to FY2014 Wage Index Change (3)	Percent Change in Hospice Payments due to Wage Index Change, additional 15% Reduction in Budget Neutrality Adjustment (4)	Percent Change in Hospice Payments due to Wage Index Change, additional 15% Reduction in Budget Neutrality Adjustment and Market Basket Update (5)
GOVERNMENT	486	8,911	-0.1%	-0.7%	1.1%
PROPRIETARY	1,982	46,438	-0.2%	-0.8%	1.0%
HOSPICE BASE:					
FREESTANDING	2,547	69,752	-0.2%	-0.8%	1.0%
HOME HEALTH AGENCY	521	9,848	0.3%	-0.3%	1.5%
HOSPITAL	458	5,574	0.0%	-0.6%	1.2%
SKILLED NURSING FACILITY	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 analytic file (SAF) as of December 31, 2012.

Note: The proposed 1.8 percent hospice payment update percentage for FY 2014 is based on an estimated 2.5 percent inpatient hospital market basket update, reduced by a 0.4 percentage point productivity adjustment and by 0.3 percentage point. Starting with FY 2013 (and in subsequent fiscal years), the market basket percentage update under the hospice payment system as described in section 1814(i)(1)(C)(ii)(VII) or section 1814(i)(1)(C)(iii) of the Act will be annually reduced by changes in economy-wide productivity as set out at section 1886(b)(3)(B)(xi)(II) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under section 1814(i)(1)(C)(v) of the Act).

REGION KEY:
NEW ENGLAND=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; MIDDLE ATLANTIC=Pennsylvania, New Jersey, New York; SOUTH ATLANTIC=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; EAST NORTH CENTRAL=Illinois, Indiana, Michigan, Ohio, Wisconsin; EAST SOUTH CENTRAL=Alabama, Kentucky, Mississippi, Tennessee; WEST NORTH CENTRAL=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; WEST SOUTH CENTRAL=Arkansas, Louisiana, Oklahoma, Texas; MOUNTAIN=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; PACIFIC=Alaska, California, Hawaii, Oregon, Washington; OUTLYING=Guam, Puerto Rico, Virgin Islands

Table 9 shows the results of our analysis. In column 1, we indicate the number of hospices included in our analysis as of December 31, 2012, which had also filed claims in FY 2012. In column 2, we indicate the number of routine home care days that were included in our analysis, although the analysis was performed on all types of hospice

care**.** Columns 3, 4, and 5 compare FY 2013 estimated payments with those estimated for FY 2014. The estimated FY 2013 payments incorporate a BNAF, which has been reduced by 55 percent. Column 3 shows the percentage change in estimated Medicare payments for FY 2014 due to the effects of the updated wage data only, compared with estimated FY 2013 payments. The effect of the updated wage data can vary from region to region depending on the fluctuations in the wage index values of the pre-floor, pre-reclassified hospital wage index. Column 4 shows the percentage change in estimated hospice payments from FY 2013 to FY 2014 due to the combined effects of using the updated wage data and reducing the BNAF by an additional 15 percent. Column 5 shows the percentage change in estimated hospice payments from FY 2013 to FY 2014 due to the combined effects of using updated wage data, an additional 15 percent BNAF reduction, and the proposed 1.8 percent hospice payment update percentage.

The impact of changes in this proposed rule has been analyzed according to the type of hospice, geographic location, type of ownership, hospice base, and size. Table 9 categorizes hospices by various geographic and hospice characteristics. The first row of data displays the aggregate result of the impact for all Medicare-certified hospices. The second and third rows of the table categorize hospices according to their geographic location (urban and rural). Our analysis indicated that there are 2,575 hospices located in urban areas and 970 hospices located in rural areas. The next two row groupings in the table indicate the number of hospices by census region, also broken down by urban and rural hospices. The next grouping shows the impact on hospices based on the size of the hospice's program. We determined that the majority of hospice payments are made at the routine home care rate. Therefore, we based the size of each individual hospice's

program on the number of routine home care days provided in FY 2012. The next grouping shows the impact on hospices by type of ownership. The final grouping shows the impact on hospices defined by whether they are provider-based or freestanding.

As indicated in column 1 of Table 9, there are 3,545 hospices. Approximately 44.1 percent of Medicare-certified hospices are identified as voluntary (non-profit) or government agencies; a majority (55.9 percent) are proprietary (for-profit), with 1,563 designated as non-profit or government hospices, and 1,982 as proprietary. In addition, our analysis shows that most hospices are in urban areas and provide the vast majority of routine home care days, most hospices are medium-sized, and the vast majority of hospices are freestanding.

b. Hospice Size

Under the Medicare hospice benefit, hospices can provide four different levels of care. The majority of the days provided by a hospice are routine home care (RHC) days, representing about 97 percent of the services provided by a hospice. Therefore, the number of RHC days can be used as a proxy for the size of the hospice, that is, the more days of care provided, the larger the hospice. We currently use three size designations to present the impact analyses. The three categories are-- (1) small agencies having 0 to 3,499 RHC days; (2) medium agencies having 3,500 to 19,999 RHC days; and (3) large agencies having 20,000 or more RHC days. The FY 2014 updated wage data before any BNAF reduction are anticipated to decrease payments to large hospices by 0.1 percent, to medium hospices by 0.2 percent, and to small hospices by 0.4 percent (column 3), respectively. The updated wage data and the additional 15 percent BNAF reduction (for a total BNAF reduction of 70 percent) are anticipated to decrease estimated payments to

small hospices by 0.9 percent, to medium hospices by 0.7 percent, and to large hospices by 0.7 percent (column 4). Finally, the updated wage data, the additional 15 percent BNAF reduction (for a total BNAF reduction of 70 percent), and the proposed 1.8 percent hospice payment update percentage are projected to increase estimated payments by 0.9 percent for small hospices, by 1.1 percent for medium hospices, and by 1.1 percent for large hospices (column 5).

c. Geographic Location

Column 3 of Table 9 shows the estimated impact of using updated wage data without the BNAF reduction. Urban hospices are anticipated to experience a decrease of 0.1 percent and rural hospices are anticipated to experience a decrease of 0.2 percent in payments. Urban hospices can anticipate an increase in payments in New England of 1.0 percent, in the West North Central region of 0.4 percent, in the Pacific region of 0.9 percent and in Outlying regions of 0.3 percent. Urban hospices can anticipate a decrease in payments ranging from 0.8 percent in the Mountain region to 0.4 percent in the West South Central region. Urban hospices in Middle Atlantic and East North Central are not anticipated to be affected by the updated wage data.

Rural hospices are estimated to see a decrease in payments in six regions, ranging from 2.2 percent in the Pacific region to 0.1 percent in the West South Central and Middle Atlantic regions. Rural hospices can anticipate an increase in payments in three regions ranging from 0.1 percent in the East South Central region to 0.4 percent in the East North Central region. There is no anticipated change in payments for Outlying regions due to the use of updated wage data.

Column 4 shows the combined effect of the updated wage data and the additional 15 percent BNAF reduction on estimated payments, as compared to the FY 2013 estimated payments using a BNAF with a 55 percent reduction. Overall, hospices are anticipated to experience a 0.7 percent decrease in payments, with urban hospices experiencing an estimated decrease of 0.7 percent and rural hospices experiencing an estimated decrease of 0.6 percent. All urban areas other than Outlying, Pacific and New England regions are estimated to see decreases in payments, ranging from 1.4 percent in the Mountain region to 0.2 percent in the West North Central region. Rural hospices are estimated to experience a decrease in payments in seven regions, ranging from 2.9 percent in the Pacific region to 0.1 percent in the Mountain region. Payments in the Outlying and East South Central regions are anticipated to stay relatively stable.

Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction, and the proposed 1.8 percent hospice payment update percentage on estimated FY 2014 payments as compared to estimated FY 2013 payments. Overall, hospices are anticipated to experience a 1.1 percent increase in payments, with urban hospices anticipated to experience a 1.1 percent increase in payments, and rural hospices anticipated to experience a 1.2 percent increase in payments. Urban hospices are anticipated to experience an increase in estimated payments in every region, ranging from 0.4 percent in the Mountain region to 2.2 percent in New England. Rural hospices in every region but one are estimated to see an increase in payments ranging from 0.4 percent in New England to 1.8 percent in the East South Central and Outlying regions. The Pacific region is estimated to see a decrease in payments of 1.1 percent.

d. Type of Ownership

Column 3 demonstrates the effect of the updated wage data on FY 2014 estimated payments, versus FY 2013 estimated payments. We anticipate that using the updated wage data would decrease estimated payments to proprietary (for-profit) and Government hospices by 0.2 percent and 0.1 percent, respectively. Voluntary (non-profit) hospices are expected to have no change in payments. Column 4 demonstrates the combined effects of the updated wage data and of the additional 15 percent BNAF reduction. Estimated payments to voluntary (non-profit), proprietary (for-profit) and government hospices are anticipated to decrease by 0.6 percent, 0.8 percent and 0.7 percent, respectively. Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction (for a total BNAF reduction of 70 percent), and the proposed 1.8 percent hospice payment update percentage on estimated payments, comparing FY 2014 to FY 2013. Estimated FY 2014 payments are anticipated to increase for voluntary (non-profit) hospices, for proprietary (for-profit) hospices, and government hospices, by 1.2, 1.0, and 1.1 percent, respectively.

e. Hospice Base

Column 3 demonstrates the effect of using the updated wage data, comparing estimated payments for FY 2014 to FY 2013. Estimated payments are anticipated to decrease for freestanding hospices by 0.2 percent. Estimated payments are anticipated to increase for Home Health Agency and Skilled Nursing Facility based hospices by 0.3 percent and by 0.2 percent, respectively. Hospital based hospices are estimated to experience no change in payments. Column 4 shows the combined effects of the updated wage data and reducing the BNAF by an additional 15 percent, comparing estimated

payments for FY 2014 to FY 2013. All hospice facilities are anticipated to experience decrease in payments ranging from 0.8 percent for freestanding hospices to 0.3 percent for Home Health Agency based hospices. Column 5 shows the combined effects of the updated wage data, the additional 15 percent BNAF reduction, and the proposed 1.8 percent hospice payment update percentage on estimated payments, comparing FY 2014 to FY 2013. Estimated payments are anticipated to increase for all hospices, ranging from 1.0 percent for freestanding hospices to 1.5 percent for Home Health Agency based hospices.

f. Effects on Other Providers

This proposed rule only affects Medicare hospices, and therefore has no effect on other provider types.

g. Effects on the Medicare and Medicaid Programs

This proposed rule only affects Medicare hospices, and therefore has no effect on Medicaid programs. As described previously, estimated Medicare payments to hospices in FY 2014 are anticipated to decrease by $20 million due to the update in the wage index data, and to decrease by $100 million due to the additional 15 percent reduction in the BNAF (for a total 70 percent reduction in the BNAF). However, the proposed hospice payment update percentage of 1.8 percent is anticipated to increase Medicare payments by $300 million. Therefore, the total effect on Medicare hospice payments is estimated to be a $180 million increase (1.1 percent).

h. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in Table 10 below, we have

prepared an accounting statement showing the classification of the expenditures associated with this proposed rule. Table 10 provides our best estimate of the increase in Medicare payments under the hospice benefit as a result of the changes presented in this proposed rule using data for 3,545 hospices in our database.

TABLE 10-- Accounting Statement: Classification of Estimated Expenditures, From FY 2013 to FY 2014 [in $Millions]

Category	Transfers
Annualized Monetized Transfers.....	$180
From Whom to Whom.....	Federal Government to Hospices

i. Conclusion

In conclusion, the overall effect of this proposed rule is an estimated $180 million increase in Federal Medicare payments to hospices due to the wage index changes (including the additional 15 percent reduction in the BNAF) and the proposed hospice payment update percentage of 1.8 percent. Furthermore, the Secretary has determined that this will not have a significant impact on a substantial number of small entities, or have a significant effect relative to section 1102(b) of the Act.

2. Regulatory Flexibility Act Analysis

The 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. For purposes of the RFA, we estimate that almost all hospices are small entities as that term is used in the RFA. 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 $7.0

million to $34.5 million in any 1 year), or being nonprofit organizations. While the SBA does not define a size threshold in terms of annual revenues for hospices, it does define one for home health agencies ($14 million; see http://www.sba.gov/sites/default/files/files/Size_Standards_Table(1).pdf). For the purposes of this proposed rule, because the hospice benefit is a home-based benefit, we are applying the SBA definition of "small" for home health agencies to hospices; we will use this definition of "small" in determining if this proposed rule has a significant impact on a substantial number of small entities (for example, hospices). We estimate that 95 percent of hospices have Medicare revenues below $14 million or are nonprofit organizations and therefore are considered small entities.

HHS's practice in interpreting the RFA is to consider effects economically "significant" only if they reach a threshold of 3 to 5 percent or more of total revenue or total costs. As noted above, the combined effect of the updated wage data, the additional 15 percent BNAF reduction, and the proposed FY 2014 hospice payment update percentage of 1.8 percent results in an increase in estimated hospice payments of 1.1 percent for FY 2014. For small and medium hospices (as defined by routine home care days), the estimated effects on revenue when accounting for the updated wage data, the additional 15 percent BNAF reduction, and the proposed FY 2014 hospice payment update percentage reflect increases in payments of 0.9 percent and 1.1 percent, respectively. Therefore, the Secretary has determined that this proposed rule will not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the 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 604 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 proposed rule only affects hospices. Therefore, the Secretary has determined that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

3. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 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. In 2013, that threshold is approximately $141 million. This proposed rule is not anticipated to have an effect on State, local, or tribal governments, in the aggregate, or on the private sector of $141 million or more.

VII. Federalism Analysis and Regulations Text

Executive Order 13132 on Federalism (August 4, 1999) 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 proposed rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it will not have substantial direct effects on the rights, roles, and responsibilities of States, local or tribal governments.

List of Subjects in 42 CFR Part 418

Health Facilities, Hospice Care, Medicare, Reporting and record keeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR part 418 as set forth below:

PART 418—HOSPICE CARE

1. The authority citation for part 418 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§418.311 [Amended]

2. Amend § 418.311 by removing the reference to "§ 405.1874" and adding in its place the reference "§ 405.1875".

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program) (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: April 23, 2013

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Marilyn Tavenner,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: April 25, 2013

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Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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