FYI:

FY 2020 Hospice Wage Index Proposed Rule

Part 2: The Election Statement and "Virtually All"

HOSPICE FUNDAMENTALS SUBSCRIBER EMAILS — June 2019

The Least You Need to Know:

The FY 2020 Hospice Wage Index Proposed Rule suggests the addition of an addendum to the election statement to provide greater transparency and more information to patients at the start of care, and better coordination of care with non-hospice providers. This would have to be available at the patient and family's request within the first 48 hours of care, and immediately upon request thereafter. Further, it proposes that this addendum be a new condition for payment.

Additional Information:

It's time for an important rite of spring – annual release of the proposed rule required to update the hospice Medicare wage index for the upcoming fiscal year. New rates are always of interest but the rule also deserves attention because it is a vehicle for CMS to present other proposed rule changes as well as to share data and observations. Taking time to read the document is an important part of building and maintaining regulatory competence.

AREA 3 / PART 1

Addition of an addendum to the election statement to provide greater transparency and more information to patients at the start of care

Interestingly, this section mentions twice that Medicare hospice care services provided are intended to be virtually all care that is needed by terminally ill patients. That is just in the first paragraph! The rest of this section returns to this theme repeatedly, and it is the platform upon which this section of the proposed rule rests.

The first part of this section describes the existing requirements for the hospice election statement:

- Identification of the hospice and the attending physician (if any)
- Acknowledgement that the patient understands the palliative rather than curative nature of hospice care
- Acknowledgement of the fact that the patient waives the right to Medicare payment for the terminal illness and related conditions, and continues to be eligible for Medicare coverage for services unrelated to the terminal illness and related conditions

This section then expands on the expectations for the start of care and furnishing of services:

- The initial plan of care is initiated before admission
- The initial assessment is completed within 48 hours
- The patient has the right to be informed of their rights, and to be involved in developing the hospice plan of care and receive information on the scope of services covered by the hospice and specific limitations on those services.
- The care being billed to Medicare will be subject to review by the Quality Improvement Organization (QIO).
- Services will be consistent with the plan of care
- If a hospice chooses not to include unrelated services in the plan of care, the hospice is to document such needs and communicate and coordinate with those healthcare providers who are identified as caring for the unrelated service; referencing 418.56 (e)(5). The hospice may not simply ignore those needs.
- In the 2008 final rule, it was stressed that the intent of the plan of care requirements are to show a direct link between the needs identified in the comprehensive assessment and the plan of care developed by the interdisciplinary team

WHAT'S NEW?

Nothing new here so far, and it is reinforced that it has always been the expectation that there be early disclosure of the scope and limitations of services, and that the plan of care should involve the patient and family.

And: *"it is our long-standing position that services unrelated to the terminal illness should be exceptional, unusual and rare, given the comprehensive nature of the services covered under the hospice Medicare benefit".*

This reference is attributed to the Federal Register, December 16, 1983.

Haven't hospices been following these rules all along? *Well, not really……*

In this proposed rule, CMS states that they have heard reports from:

- Non-hospice providers that are unable to reach or hear back from hospices about coordination of services
- Hospices that are often unaware that patients have received care from non-hospice providers, which sometimes results in duplicative payments by Medicare
- Hospice patients that have been told by the hospice that the hospice would not cover drugs, items and services that the patient felt should have been covered by the hospice
- Hospice patients that were told that palliative chemotherapy and radiation were not covered by the hospice, but they were not told this until after they elected hospice.
- Physicians reporting that when referring patients for hospice care, they are told by the hospice that the Medicare hospice benefit does not cover palliative blood transfusions.

WHAT'S OF NOTE

Hospices are familiar with the unpleasant surprise of learning of a patient's hospital admission after the fact. We all remember the 2014 effort by Medicare to have medications preauthorized. After the preauth requirement was lifted for drugs not in the four common categories used in end of life care, Part D billing for these drugs by hospice beneficiaries has steadily risen!

CMS views this as a lack of coordination between hospices and Part D pharmacies, and that hospice beneficiaries are bearing the financial burden for drugs and services that should have been paid for by the hospice.

AREA 3 / PART 1

Lack of Coverage Transparency?

Reports made by patients, families and medical professionals to CMS and the Medicare Ombudsman suggest that there is a lack of coverage transparency, and a narrow view of the overall condition of the patient. This is viewed as resulting in a "non-trivial" number of items, services and drugs for potentially related conditions being provided to hospice patients by non-hospice providers, when the hospice should have been responsible.

The Proposed Rule even notes that ***"the Medicare hospice benefit does cover services for pain and symptom management, including palliative chemotherapy, radiation and blood transfusions".***

AREA 3 / PART 2 *The Addendum*

In the interest of transparency, the proposal is to modify the hospice election statement to include the following on the election statement.

New content to be added to the requirements for hospice elections at 418.24:

- Information about the holistic, comprehensive nature of the Medicare Hospice Benefit
- A statement that, although it would be rare, there could be some necessary items, drugs or services that will not be covered by the hospice because the hospice has determined that those items, drugs or services are to treat a condition unrelated to the terminal illness and related conditions
- Information about beneficiary cost sharing for hospice services
- Notice of the beneficiary's right to request an election addendum that includes a written list and rationale for the conditions, items, drugs or services that the hospice has determined to be unrelated to the terminal illness and related conditions, and that immediate advocacy is available through the QIO if the beneficiary disagrees with the hospice's determination.

WHAT'S OF NOTE

This is in addition to the existing election statement content requirements at 418.24(b). Hospices, upon request, must supply the beneficiary with a written copy of the addendum within 48 hours, if it is requested at the time of admission.

If the addendum is requested during hospice care, the hospice must provide it immediately—as it should readily be available in the medical record. If there are changes, an updated addendum must be furnished. The presence of this addendum would be a new condition for payment.

Is there a form for this new addendum?

No. But the proposed rule suggests it contain the following information and be titled "Patient Notification of Non-Covered Items, Services and Drugs."

1. **NAME** of the hospice;
2. **BENEFICIARY'S NAME** and hospice medical record identifier;
3. Identification of the beneficiary's **TERMINAL ILLNESS** and related conditions;
4. A list of the beneficiary's **CURRENT DIAGNOSES/CONDITIONS** present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs, not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions;
5. A written **CLINICAL EXPLANATION**, in language the beneficiary and his or her representative can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation would be accompanied by a general statement that the decision as to whether conditions, items, services, and drugs is related is made for each patient and that the beneficiary should share this clinical explanation with other health care providers from which they seek services unrelated to their terminal illness and related conditions;
6. **REFERENCES** to any relevant clinical practice, policy, or coverage guidelines;
7. Information on the **PURPOSE OF THE ADDENDUM** and the right to immediate advocacy from the QIO, and contact information for the QIO;
8. **NAME AND SIGNATURE** of Medicare hospice beneficiary (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the beneficiary's agreement with the hospice's determinations.

Finally, CMS proposes that the above requirements for the addendum be conditions for payment.

The Proposed rule is clear that while the communication of unrelated conditions to beneficiaries and non-hospice providers is already required, making it a condition for payment in this way will ensure that hospices are diligent in providing the information. It is also suggested that this will not result in increased burden to hospices, since hospice regulations already require assessment and documentation of unrelated conditions.

What is a QIO?

A Medicare Quality Improvement Organization – a QIO – is a Medicare contractor with three core functions:

1. Improving quality of care for Medicare beneficiaries
2. Protecting the integrity of the Medicare Trust fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
3. Protecting beneficiaries by expeditiously addressing individual complaints, such as
   - **a.** complaints
   - **b.** provider-based notice appeals;
   - **c.** violations of the Emergency Medical Treatment and Labor Act (EMTALA); and
   - **d.** other related responsibilities as articulated in QIO-related law

Hospices are most familiar with the QIO as the contractor that advocates for patients and families that disagree with the hospice's decision to discharge a patient.

Actions of a Prudent Hospice™

ONE. Check your hospice's existing election form. Does it ensure that the existing requirements are met?

TWO. Review your current processes for determining and documenting what is related and unrelated and how this is communicated to patients and families.

THREE. Share your hospice's comments and concerns during the comment period and participate in Open Door Forums.

FOUR. Check your processes for communicating with others that are providing care and services to your patients. How do you communicate they are a hospice patient and how they should be billing?

Last Day to Comment

The last date to submit comments is June 18, 2019. Instructions for submission are in the Federal Register proposed rule.

The 2020 *Proposed Wage Index FYIs*

Part 1: Proposed Rebasing of the Continuous Home Care, Inpatient Respite Care, and General Inpatient Care Payment Rates for FY 2020, Proposed FY 2020 Hospice Wage Index and Rate Updates

Part 2: Proposed Election Statement Content Modifications and Proposed Addendum To Provide Greater Coverage Transparency and Safeguard Patient Rights

Part 3: The Hospice Quality Reporting Program

Part 4: Request for information on the interaction of the hospice benefit with Medicare Advantage, Accountable Care Organizations and other alternative care delivery models

Link to Other Material:

The Proposed Rule
https://www.federalregister.gov/documents/2019/04/25/2019-08143/medicare-program-fiscal-year-2020-hospice-wage-index-and-payment-rate-update-and-hospice-quality

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