CMS Finalizes Hospice Payment, Reporting, and Other Changes

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In a final rule published in the Federal Register on August 6, the Centers for Medicare and Medicaid Services (CMS), implemented several important changes in the hospice payment framework and FY 2020 rates, as well as modifications to the hospice election statement and the Hospice Quality Reporting Program (HQRP).

Payment Changes

- **Rebasing of the Continuous Home Care (CHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP) Payments for FY 2020** – CMS noted that base payment rates for each level of care were set in 1983 and were changed very little over the years. After analyzing the rates in the context of technological changes in the field, changes in patient population, and more accurate data regarding the cost of providing care, the agency concluded that payments for CHC, IRC, and GIP would need to be increased by 36.6 percent, 161.2 percent, and 31 percent, respectively, to align payments with the cost of providing care at these levels. By contrast, the same analysis for Routine Home Care (RHC) revealed that payment rates presently exceed the cost of care by 18.1 percent during Days 1-60 and 19.3 percent for Day 61 and beyond. Changes in hospice payment rates must be accomplished in a budget-neutral manner as required by Section 1814(i)(6)(D)(ii) of the Social Security Act. Accordingly, CMS calculated that RHC payments would need to be reduced by 2.72 percent[1] to achieve budget neutrality with increases in the CHC, IRC, and GIP payments.[2]

- **Hospital Wage Index Lag Elimination** – Presently, the wage index values for hospice have been calculated using the prior fiscal year's pre-floor, pre-reclassified hospital wage index. The final rule eliminates this one-year "lag." CMS stated in the rule that the change will produce a "0.0 percent" impact in FY 2020, again because such changes must be implemented in a budget neutral manner. However payments for some types of hospice providers will be reduced by up to 0.3 percent.

- **FY 2020 Hospice Wage Index** – The hospice wage index is used to adjust payment rates for hospice agencies to reflect wage differences in various locations. It is based on wage adjustment factors used to adjust the hospital wage index. CMS explained in the rule that a programming error with respect to the data used to compute the wage index for the proposed rule affected the wage index values nationwide. CMS corrected the error and made the final FY 2020 index available on its website.

- **Payment Update** – The final rule establishes a payment update of 2.6 percent. When the rebasing and other adjustments discussed in the rule are factored in, the FY 2020 payment

1 CMS noted that reducing the RHC payment rate to align with the cost of care would require more than a 2.72 percent reduction. As a result, the reduction is not considered by the agency to be a rebasing of the RHC payment rate. See 84 Fed. Reg. 38484 (Aug. 6, 2019), at 38492.

2 Despite the pronounced misalignment of CHC, IRC, and GIP payments to cost of care, these services are far less heavily utilized than RHC, and therefore, a small percentage reduction in RHC payments achieves the required budget neutrality. See *Id.*, at 38487 (RHC accounts for 97.6 percent of total hospice days; GIP, CHC, and IRC account for 1.7 percent, 0.4 percent, and 0.3 percent of total hospice days, respectively).

rates are as follows:

- **RHC (Days 1-60)** - $194.50 per day
- **RHC (Day 61+)** - $153.72 per day
- **CHC** - $58.15 hourly rate (8-hour minimum)
- **IRC** - $450.10 per day
- **GIC** - $1,021.25 per day

- **Hospice Cap Amount** - The hospice cap amount for FY 2020 will be $29,964.78, which represents the FY 2019 cap increased by the 2.6 percent hospice payment update.

Election Statement Content Modifications and Addendum

CMS explained in the final rule that it received anecdotal reports from both hospice providers and non-hospice providers that indicated a failure of communication between the two regarding services provided to hospice beneficiaries. Further, CMS noted its concern over the substantial financial burden posed by hospice beneficiary cost-sharing responsibility for non-hospice services. As a result, the agency sought to promote coverage transparency and facilitate communication among providers by finalizing proposals that would modify the content requirements for the hospice election statement and provide for an addendum to the election statement, upon the request of hospice patients, their representatives, non-hospice service providers and Medicare contractors, that would provide information concerning conditions, items, services, or drugs that are unrelated to the hospice patient's terminal illness and related conditions and thus are not covered by the hospice. Specifically, for **hospice elections beginning on or after October 1, 2020**, the final rule makes the following changes to 42 C.F.R. § 418.24:

- Election Statement – Section 418.24(b)
  - In addition to the acknowledgement that the individual has been provided information on the hospice's coverage responsibility, the hospice must provide the individual with information indicating that services unrelated to the terminal illness and related conditions are "exceptional and unusual and hospice should be providing virtually all care needed by the individual . . . ."
  - The hospice must provide information on individual cost-sharing for hospice services.
  - The hospice must provide notification of the individual's (or representative's) right to receive an election statement addendum if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions.
  - The hospice must provide information on the Beneficiary and Family Centered Care Quality Improvement Organization ("BFCC-QIO") that includes contact information and a statement regarding the right to seek "immediate advocacy" from that organization.

- Election Statement Addendum – Section 418.24(c)
  - Basic Requirement - The hospice patient (or the patient's representative), non-hospice providers furnishing items, services or drugs unrelated to the patient's terminal illness and related conditions, or Medicare contractors, may request a written list of the conditions, items, services, or drugs that the hospice has determined are unrelated. If the addendum is requested at the time of initial hospice election, the hospice must provide it within 5 days of the date the election was made. If the request is made during the course of hospice care, the addendum must be provided within 72 hours of the request. In the event that there are changes to the content of the addendum during the course of hospice care, the hospice must provide an updated addendum. Curiously, the regulatory language requires that the updated addendum be provided only to the hospice patient (or representative), and CMS did not specify a time frame for delivery of the update.
  - Specific Contents

- The addendum must be titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs."
- Name of the hospice.
- Hospice patient's name and hospice medical record identifier.
- Identification of the terminal illness and related conditions.
- List of the conditions present on admission (or update of the care plan) and the associated items, services, and drugs determined by the hospice to be unrelated to the terminal illness and related conditions and thus not covered by the hospice.
- A written clinical explanation, in language the patient (or representative) can understand, as to why the conditions, items, services, or drugs are not covered. This must include a statement that the decision by the hospice is made for each patient and that the patient should share the explanation with other health care providers.
- References to any relevant clinical practice, policy, or coverage guidelines.
- Information on the purpose of the addendum and the right to immediate advocacy from the BFCC-QIO.
- Name and signature of the patient (or representative), date signed, and a statement that signing the addendum is only an acknowledgement of receipt of the addendum and does not constitute agreement with the determinations made by the hospice.

CMS received a host of comments to this portion of the rule as proposed. Because of the "operational and logistical issues" highlighted in those comments, CMS stated that it will continue to examine some of those issues to determine whether any additional proposals are required for FY 2021 rulemaking.

Hospice Quality Reporting Program (HQRP) Updates

CMS provided updates in the rule to several aspects of the HQRP, most notably the following:

- **Claims-based and Outcome Measures** - CMS stated that it intends to develop both claims-based and outcome measures for the HQRP in the future as part of the agency's Meaningful Measures Initiative. CMS pointed out that claims-based data, while limited in terms of their reflection of care processes and patient outcomes, have several advantages in that they place a minimal burden on providers, follow a relatively consistent format, create an abundant and standardized source of patient information, and are amenable to analysis. CMS noted that quality reporting programs in other settings also utilize claims-based measures, which are endorsed by the National Quality Forum. Outcome measures, by contrast, are directly focused on measuring such core indicators of quality in hospice as pain and symptom management, or for identifying the value of different staff providing care at different times. CMS did not propose any specific claims-based or outcome measures in the final rule.

- **Claims-based Measures under Development** – CMS previously had identified two high-priority claims-based measures: potentially avoidable hospice care transitions, and access to levels of hospice care. Based on feedback from the Measures Application Partnership and its own analysis, CMS stated that it has decided to revisit both of these measures.

- **Public Reporting of "Hospice Visits When Death is Imminent" Measure Pair** – The pair consists of Measure 1 (percentage of patients receiving at least one visit from a registered nurse, physician, nurse practitioner, or physician assistant in the last three days of life) and Measure 2 (percentage of patients receiving at least two visits from social workers, chaplains or spiritual counselors, licensed practical nurses, or aides in the last seven days of life). CMS reported that Measure 1 met readiness standards for public reporting but Measure 2 did not. Accordingly, only Measure 1 will be publicly reported, though CMS intends to continue work on Measure 2. Data collection, however, will not change.

- **Posting Information from Government Data Sources on Hospice Compare** – CMS proposes to post, as soon as FY 2020, information that utilizes publicly available government data from agencies other than CMS, such as the U.S. Census Bureau, the Centers for Disease Control and Prevention, the Bureau of Labor Statistics, and the National Institutes of Health. CMS believes these sources present supplementary information that could prove helpful to both consumers and providers. CMS intends to craft explanatory language to ensure that consumers understand that the data are meant for informational purposes only.

Conclusion

One of the chief concerns arising out of the rebasing of CHC, IRC, and GIP payments is the potential for a disproportionate increase in the utilization of these levels of care over RHC. However, CMS specifically stated in its narrative that it will be monitoring utilization rates to ensure that these level of care are used appropriately. Another concern with the rule lies with the election statement addendum requirement. The requirement will increase the administrative burden of providers, and most certainly non-hospice providers and Medicare contractors will avail themselves of the right to request them as a means of scrutinizing hospice providers' determinations as to whether a condition, item, service, or drug is unrelated to a patient's terminal illness and related condition.

The final rule becomes effective on October 1, 2019, though as noted above, most of the changes to the election statement will take effect on October 1, 2020.

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