FY 2020 Hospice Proposed Rule

CMS released the FY 2020 Hospice Proposed Rule on April 19, 2019. The comment period closes June 18, 2019.

Payment Updates

CMS proposes an overall net increase of 2.7 percent or $540 million (3.2 percent market basket increase, offset by a 0.5 percent productivity reduction). The proposed Hospice Cap Amount for FY 2020 is $29,993.99 (the FY 2019 cap amount updated by 2.7 percent).

The Rule also rebases (i.e., increases) the continuous home care (CHC), general inpatient care (GIP), and the inpatient respite care (IRC) per diem payment rates in a budget-neutral manner to more closely align Medicare payments with the costs of providing care and subsequently decreases routine home care (RHC) payment by 2.71 percent to ensure overall budget neutrality. (Note: RHC days accounted for 98.2 percent of all hospice days in FY 2018.)

Table 8: Comparison of FY 2019 Average Costs to Payments for CHC, IRC and GIP

Level of Care	Estimated FY19 Avg Costs/Day	FY19 Per Diem Payment Rates	Estimated % Increase to Align with Costs
Continuous Home Care (CHC)	$1363.26 ($56.80/hour)	$997.38 ($41.56/hour)	+36.6%
Inpatient Respite Care (IRC)	$457.61	$176.01	+160.0%
General Inpatient Care (GIC)	$994.45	$758.07	+31.2%

Table 9: Comparison of FY 2019 Average Costs to Payments for RHC

Level of Care	Estimated FY19 Avg Costs/Day	FY19 Per Diem Payment Rates	% Difference between Payment & Costs
Routine Home Care (RHC) Days 1-60	$171.89	$196.25	+14.2%
Routine Home Care (RHC) Days 61+	$118.95	$154.21	+29.6%

Based on this information, CMS is proposing to rebase payment for CHC, IRC, and GIP as follows:

Table 10: Proposed Rebased Payment Rates for CHC, IRC, and GIP (prior to application of the hospice payment update percentage of 2.7 percent, and the IRC rate accounts for 5 percent coinsurance)

Level of Care	Proposed Rebased Payment Rates
Continuous Home Care (CHC)	$56.80 per hour / $1363.26 per day
Inpatient Respite Care (IRC)	$432.82
General Inpatient Care (GIC)	$994.45

Proposed Wage Index Lag Elimination: CMS is proposing to align the wage index update with the acute care hospital IPPS and other payment systems (i.e., use the "pre-floor, pre-reclassified hospital wage index from the current fiscal year" instead of the prior fiscal year). This aligns hospice with SNF PPS and HH PPS.

For RHC, the proposed FY 2020 payment rates are the proposed FY 2019 rates, reduced by a budget neutrality factor as a result of the rebasing of CHC, IRC and GIP, adjusted by the SIA (Service Intensity Add-on) budget neutrality factor, adjusted by the wage index standardization factor and increased by the 2.7 percent proposed hospice payment update percentage.

Table 12: Proposed FY 2020 Hospice RHC Payment Rates

Code	Description	Proposed FY19 budget-neutral RHC payment rates	SIA budget neutrality factor	Wage Index standardization factor	Proposed FY20 hospice payment update	Proposed FY20 payment rates
651	RHC Days 1-60	$190.93	X 0.9924	X 1.0054	X 1.027	$195.65
651	RHC Days 61+	$150.03	X 0.9982	X 1.0054	X 1.027	$154.63

The proposed FY 2020 rebased payment rates for CHC, IRC and GIP are the proposed rebased FY 2019 payment rates, adjusted by the wage index standardization factor and increased by the 2.7 percent proposed hospice payment update percentage.

Table 13: Proposed FY 2020 Hospice CHC, IRC and GIP Payment Rates

Code	Description	Proposed FY19 rebased payment rates	Wage Index standardization factor	Proposed FY20 hospice payment update	Proposed FY20 payment rates
652	CHC – Full rate = 24 hrs of care ($56.80/hour)	$1363.26	X 1.0041	X 1.027	$1405.81
655	IRC	$435.82	X 1.0049	X 1.027	$449.78
656	GIC	$994.45	X 1.0060	X 1.027	$1027.43

Modifications to Hospice Election Statement

CMS proposes to modify the hospice election statement by content modifications and requiring an addendum to "provide greater coverage transparency and safeguard patient rights." CMS states, "We believe that hospices are required to provide virtually all of the care needed by the terminally ill individual (48 FR 56010). Any services needed outside of the hospice benefit (that is, "unrelated") should be exceptional and unusual."

CMS proposes hospices be required to include the following (in addition to existing election statement at §418.24(b)) on the election statement:

- 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 hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.
- Information about beneficiary cost-sharing for hospice services.
- Notification of the beneficiary's (or representative's) right to request and election statement 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 BFCC-QIO [Beneficiary and Family Centered Care-Quality Improvement Organization] if the beneficiary (or representative) disagrees with the hospice's determination.

CMS proposes hospices be required, upon request, to provide to the beneficiary (or representative) an election statement addendum – titled *Patient Notification of Hospice Non-Covered Items, Services, and Drugs* – with a list and rationale for the conditions, items, services, and drugs that the hospice has determined as unrelated to the terminal illness and related conditions. And, CMS proposes that hospices be required to provide this election statement addendum upon request, (1) to other non-hospice providers that are treating such conditions, and (2) to Medicare contractors who request such information.

If requested at the time of hospice election, the hospice must provide this information, in writing, to the individual (or representative) *within 48 hours of the request*. If requested during the course of hospice care, the hospice must provide it in writing *immediately* to the requesting individual (representative), non-hospice provider or Medicare Contractor, as this information should be readily available in the beneficiary's hospice medical record.

The addendum would include the following information:

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/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 or not conditions, items, services, or drugs is related is made for each patient and that the beneficiary should share this clinical explanation with other health 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 following domains:
    - Purpose of Addendum
        - The purpose is to notify the hospice beneficiary (or representative) of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the beneficiary's terminal illness and related conditions.
        - The addendum is subject to review and shall be updated, as needed, when the plan of care is updated in accordance with §418.56. The hospice will provide these updates, in writing, to the beneficiary (or representative).
    - Right to Immediate Advocacy – The addendum must include language that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice's determination. Specifically, the language must include contact information for the BFCC-QIO, as well as the following statement: *"We encourage you to contact your hospice provider to discuss any concerns about the diagnoses/conditions, as well as items, services, and medications listed on this form that you believe should be covered by the hospice. Beyond issues related to Medicare coverage, if you believe that your care concerns were not adequately addressed by your hospice provider, you may contact the Medicare Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) to help you. While it cannot require services be covered, provided, or be paid for by Medicare, the BFCC-QIO can assist you: (a) verbally engaging providers*

on your behalf to seek quick resolution, known as Immediate Advocacy, or (b) by having an independent physician review of your medical documentation to determine if there was a quality issue."

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 and not necessarily the beneficiary's agreement with the hospice's determinations.

The signed addendum (and any signed updates) would be a new condition for payment. The hospice election statement addendum would only be required for beneficiaries who request it, though hospices may choose to provide it to all of their hospice patients, regardless of payer source (after making any necessary adjustments for the specific payer).

Typically, completing this addendum would be the responsibility of the hospice nurse (RN) responsible for the patient's plan of care, but hospices can determine which member of the interdisciplinary group (IDG) would complete it. There is no specific required form for this addendum; hospices can design it in a format to meet their needs. If finalized, CMS will post a model election statement with added content requirements and a model addendum.

Request for Information (RFI): Role of Hospice and Coordination of Care at End-of-Life

As part of "delivery system transformation," CMS seeks information on the interaction of the hospice benefit and various alternative care delivery models, including Medicare Advantage (MA), Accountable Care Organizations (ACOs), and other future models designed to change incentives under fee for service Medicare. CMS requests information on the impact of alternative delivery and payment models implemented outside of the Medicare program on the provision of hospice care – What should CMS consider for the future design of the hospice benefit?

CMS is testing ways to incorporate hospice into other care delivery models (e.g., incorporating hospice into MA). This is a voluntary model. Beginning in 2021, MA enrollees in participating plans will have hospice care provided through their chosen MA plan. Through this RFI, CMS is seeking public comments on other broader approaches.

Updates to Hospice Quality Reporting Program (HQRP)

No new measures for HQPR for FY 2020; failure to report results in 2% market basket decrease for applicable payment year (e.g., FY 2017 reporting affects FY 2019 payment). CMS is soliciting public comments and suggestions related to ideas for future claims-based and outcome measure concepts and quality measures in the HQRP that could also be tied to the Meaningful Measures initiative.

CMS has identified two high priority areas to be addressed by claims-based measure development (potentially avoidable hospice care transitions and access to levels of hospice care) and continues to consider appropriate and effective ways to measure these concepts.

CMS discusses items related to public reporting of quality measures and government data (e.g., Hospice Public Use File (PUF)) on Hospice Compare as well as recommendations for the Hospice CAHPS program in FY 2023 and beyond.

Updates to the Hospice Assessment Tool

Although hospice care differs from other PAC settings, "there is a need to create a comprehensive assessment instrument for hospice care to align with other PAC settings, where feasible and practical." CMS will continue to engage stakeholders in discussions and development of a comprehensive tool that will include ability to "establish goals of care that embrace the individual's values and preferences." CMS is seeking public comment on a name for this tool. It will not be called the HEART (Hospice Evaluation Assessment Reporting Tool) as previously discussed.

Projected Impact to Hospices for FY 2020

CMS has provided a provider-specific impact analysis file to help providers understand the potential impacts of the proposed wage index with and without the lag and the proposed rebasing of CHC, IRC and GIP.

Simulated payments are based on utilization in FY 2018 and only include payments related to the level of care (does not include payments related to the SIA).

Overall, non-profit and government hospices (both freestanding and home health agency-based) fare better in FY 2020 than for-profit ones; urban fares slightly better than rural; and large hospices (20,000+ RHC days) do better than small.

Resource

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