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FY 2020 Hospice Final Rule

On July 31, 2019, CMS released the FY 2020 Hospice Final Rule which outlines payment updates, modifications to the hospice election statement, and updates to the hospice quality reporting program.

Payment Updates:

CMS finalized an overall net increase of 2.6% or $520 million (i.e., 3.0% market basket increase, offset by a 0.4% productivity reduction). CMS also finalized the FY 2020 hospice cap amount at $29,964.78 (FY 2019 cap amount updated by 2.6%).

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 2.72% to ensure overall budget neutrality.

CMS finalized its decision to eliminate the wage index lag and align the hospice wage index update with the acute care hospital IPPS and other payment systems (SNF PPS, HH PPS). Beginning in FY 2020, CMS will use the "pre-floor, pre-reclassified hospital wage index from the current fiscal year" instead of the prior fiscal year.

Table 10: FY 2020 Hospice RHC Payment Rates

Code	Description	FY19 rebased payment rates*	SIA budget neutrality factor	Wage Index standardization factor	FY20 hospice payment update	FY20 payment rates
651	Routine Home Care (days 1-60)	$190.91	X 0.9924	X 1.0006	X 1.026	$194.50
651	Routine Home Care (days 61+)	$150.02	X 0.9982	X 1.0005	X 1.026	$153.72

Table 11: FY 2020 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY19 rebased payment rates	Wage Index standardization factor*	FY20 hospice payment update	FY20 payment rates
652	Continuous Home Care (CHC) – Full rate + 24 hours of care	$1363.26 ($56.80/hour)	X 0.9978	X 1.026	$1395.63 ($58.15/hour)
655	Inpatient Respite Care (IRC)	$437.86	X 1.0019	X 1.026	$450.10
656	General Inpatient Care (GIC)	$992.99	X 1.0024	X 1.026	$1021.25

*Transition from FY 2019 Wage Index to FY 2020 Wage Index without 1-year lag

Modifications to Hospice Election Statement and Addendum:

CMS finalized modifications to the hospice election statement and the implementation of a new election statement addendum to be implemented October 1, 2020 (FY 2021).

Hospices are required to include the following on the election statement, in addition to existing election statement requirements at §418.24(b):

1. Information about the holistic, comprehensive nature of the Medicare hospice benefit
2. 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
3. Information about beneficiary cost-sharing for hospice services
4. 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

Hospices will 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 finalized that hospices will also be required to provide this election statement addendum upon request to: 1) other non-hospice providers that are treating such conditions, and 2) Medicare contractors who request such information.

In the final rule, CMS modified the proposed time frame requirements for issuing the addendum as follows:

- If requested at the time of hospice election, the hospice must provide this information, in writing, to the individual (or representative) ***within 5 days of the request,*** (vs. the proposed 48-hour time frame) consistent with the time frame requirements for the comprehensive assessment. If the beneficiary dies within the first 5 days of the hospice election, hospices would not be required to complete a requested addendum – this requirement would be deemed as being met.
- If requested during the course of hospice care, the hospice must provide it ***within 72 hours*** (vs. "immediately" as described in the proposed rule) 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 must 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) will be a new condition for payment. This does not mean that the beneficiary (or representative) or non-hospice provider must agree with the hospice's determination, but that the signed addendum is only acknowledgement of the receipt of the addendum (or its updates) and the payment requirement would be met if there was a signed addendum (or update) in the hospice medical record. The addendum would be not be required to be submitted with any hospice claims.

The hospice election statement addendum is only required for beneficiaries who request it, though hospices may choose to provide it to all of their hospice patients. CMS states they would "expect hospices to document, in some fashion, that the addendum was discussed with the patient (or representative) at the time of admission…Likewise, hospices can develop a way to document whether or not the addendum was requested at the time of hospice election (or at any time throughout the course of hospice care).” CMS also emphasized that the purpose of the addendum is to “keep patients at the forefront of their decision-making” and to ensure they have adequate information to make care choices at end of life. The addendum is not “punitive against hospices” or a way for CMS to deny hospice claims.

“We do not want hospices to perceive that the purpose of this addendum is punitive against hospices, nor that it is a mechanism to deny claims; rather we want hospices to understand that the intent of this addendum is to keep patients at the forefront of their decision-making equipped with adequate information to make care choices as they approach the end of life.”

Typically, completing this addendum would be the responsibility of the hospice RN responsible for the patient’s plan of care, but CMS states 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. CMS will post a model election statement with added content requirements and a model addendum.

Updates to Hospice Quality Reporting Program (HQRP):

There are no new measures for the 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 solicited 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, specifically measures related to two high-priority areas of care: potentially avoidable hospice care transitions and access to levels of hospice care. In the final rule they acknowledge the comments received and express their intent to continue to expand the HQRP in clinically meaningful and relevant ways.

CMS states it is considering changes/revisions to the CAHPS® Hospice survey including:

- Ways to simplify and shorten the survey
- Using web-based data collection in conjunction with traditional survey methods
- Making language “friendlier”
- Possible changes to timeframe of survey completion

And, starting with FY 2022, CMS will provide an automatic exception (for CAHPS®) for any hospice that is an active agency, and according to CMS data sources, served few than fifty unique decedents/caregivers in the reference year. This automatic exception would be good for one year and would be reassessed in subsequent years.

Updates to the Hospice Assessment Tool:

CMS finalized the name **Hospice Outcomes & Patient Evaluation, or HOPE**, as the new assessment tool. This new tool is being prepared for implementation, and the timeline for roll-out will be established through rule-making.

Projected Impact to Hospices for FY 2020:

CMS has provided a provider-specific impact analysis file on their website to help providers understand the potential impacts of the wage index changes and the rebasing of CHC, IRC and GIP. (Access the file **here**)

In addition, CMS provides a general overview of projected impact by provider type in the final rule. Overall, non-profit and government hospices (both freestanding and HHA-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. Part of this table is reproduced below:

Table 24: Impact to Hospices for FY 2020

	Hospices	Rebasing of CHC, IRC, GIP	FY 2020 Updated Wage data without 1-year lag	FY 2020 Hospice payment update	Total Impact for FY 2020
All Hospices	4,599	0.0%	0.0%	2.6%	2.6%
Hospice Type & Control					
Subtotal: Freestanding	3,809	0.0%	0.0%	2.6%	2.6%
Subtotal: Provider/HHA	790	0.2%	-0.1%	2.6%	2.7%
Subtotal: Non-profit	998	1.2%	0.0%	2.6%	3.8%
Subtotal: For profit	3,039	-0.8%	0.0%	2.6%	1.8%
Subtotal: Government	140	0.2%	-0.2%	2.6%	2.6%
Subtotal: Other	422	0.3%	0.1%	2.6%	3.0%
Hospice Location					
Rural	880	-0.8%	0.0%	2.6%	1.8%
Urban	3,719	0.1%	0.0%	2.6%	2.7%
Hospice Size					
0-3,499 RHC days (small)	1,004	-1.0%	0.2%	2.6%	1.8%
3,500-19,999 RHC days	2,131	-1.1%	0.0%	2.6%	1.5%
20,000+ RHC days (lg)	1,464	0.3%	0.0%	2.6%	2.9%

Access the Final Rule **here**.

CMS's Fact Sheet is available **here**.