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The FY2020 Hospice Final Rule: How Final Is it?

Agenda

- Overview
- Proposed Rule's Purpose
- Comments Do Affect Final Rules
- Financial Impacts
- Public Reporting
- Election Statement Modifications and Addendum
- HOPE Hospice Outcome and Patient Evaluation Tool

Overview

First, CMS Proposes Rule Changes

- Each April:
  - CMS releases FY Proposed Rule.
    - Identifies findings and analysis of claims and public reporting analysis.
    - Sets forth new rules CMS plans based on this information.
      - Financial updates/changes for industry.
      - Quality reporting updates.
    - Requests public comments on proposals.
      - Law states 60 days for comment period.

What Is A FY Final Rule?

- Each July or August:
  - CMS releases FY Final Rule.
    - Must address all comments (sometimes grouping like ones).
    - Finalizes rules for hospice in both financial updates and public reporting.
    - Becomes law Oct 1 of the same year, unless otherwise specified.
- Begins again the following spring.

ule is Final — Until Next Year

- Proposed rule doesn't automatically translate into final rule, but does if no stronger argument is made.
  - CMS required by law to address comments.
  - Public input is our right to be heard.
  - As industry leaders and experts, commenting is our obligation when proposed rule elements could/will harm the industry and those we serve.
  - Comments **did** affect FY 2020 Hospice Final Rule.

FY 2020 Hospice Final Rule

- Takes effect Oct 1, 2019.
  - Fiscal year, not calendar year.
  - Except where otherwise specified.
- Published and available in Federal Register online.
  - *https://federalregister.gov/d/2019-16583* and on *govinfo.gov*

pdates/Changes in FY 2020 Final Rule

- Hospice Wage Index.
- Payment Rate Increase.
- Cap Amount.
- Election Statement Changes.
- Added Election Statement Addendum.
- Updates to Hospice Quality Reporting Program.

Proposed Rule's Purpose

oposed
ule

- Transparent report of CMS contractors' scrutiny.
  - Highlights CMS' and OIG's concerns about hospice provider behaviors, such as questionable billing practices, incomplete documentation and failure to comply with hospice Conditions of Participation.
- Explains why each rule change is proposed.
  - Usually tied to scrutiny effort findings, details why each proposal is justified, what CMS' goal is that the change is intended to achieve, and what further scrutiny and/or future revisions are planned.

Proposed Rule

- Provides opportunity for response from anyone and everyone who cares.
- Some proposals have changed, been postponed, or abandoned altogether based on public comments.
  - For Example (from FY 2020 Hospice Final Rule
    - The majority of commenters agreed that if the **addendum** is finalized, the effective date should be **delayed until FY 2021**. . . Therefore, we will finalize an **effective dat of FY 2021 for the election statement modifications and the addendum.**

roposed Rule

- Without comments recommending alternatives, the proposed rule generally does become the final rule.

Comments Do Affect Final Rules

CMS Must Respond To Each Comment

- **CMS must respond to each comment.**
  - ***Comment:*** Several commenters stated that we should take into consideration [for CAHPS Survey Case Mix] hospice characteristics, including rural versus urban, and hospice size.
  - ***Final Decision:*** We appreciate the feedback on potential changes to the CAHPS® Hospice Survey and will take these comments into consideration as we consider changes. Any potential changes will be proposed through future rulemaking.

Grouping Comments Of Same Topic Occurs

MS must respond to each comment.

Comment: Several commenters noted that the changes to the IRC per diem payments would make it easier to provide respite care . . . A large number of commenters stated that upward adjustment for CHC, GIP, and IRC is warranted given the misalignment between payment and costs.

Response: We appreciate these comments and agree that rebasing the IRC payment rate may result in greater access to inpatient respite care . . . Likewise, the rebasing proposals help to align payment with the cost of providing care . . . [are] responsive to industry concerns and challenges related to providing these higher intensity levels of care.

Acknowledging With Correction Is Common

esponding doesn't always mean CMS agrees.

Response: While we appreciate the commenters' careful review of the proposal and the support for the removal of the wage index lag elimination, we reiterate that using the most current year's data will most accurately adjust payment to account for geographic wage differences.

Response: We appreciate MedPAC's recommendations; however, we do not have the authority to repeal the existing hospital wage index absent Congressional action.

Tome For Teaching Moments

MS sometimes seizes opportunities to teach.

Response: We appreciate the commenter's suggestion to consider looking into the practices of hospices that regularly reach or exceed the annual aggregate cap amount to target further program integrity investigations. We remind stakeholders that . . . discharging a beneficiary solely to avoid exceeding the cap limit is in violation of the regulations at § 418.26 and may cause undue distress and potential harm to terminally ill patients who would have to seek care outside of the hospice benefit.

Comments Can Change Final Decisions

ometimes, comments sway CMS decisions.

Comment: The majority of commenters agreed that if the addendum is finalized, the effective date should be delayed until FY 2021.

Response:

- Effective date of FY 2021 for the election statement modifications and the addendum.
  - Hospices need time to prepare.
  - CMS needs to meet with MACs about the payment condition logistics.

Financial Update

date Hospice Payment System

Updates the hospice wage index, payment ates, and cap amount for fiscal year (FY) 020.

Rebases per diem payment rates in a budget neutral manner to more accurately align payments with the costs of providing:

- Continuous home care (CHC).
- General inpatient care (GIP).
- Inpatient respite care (IRC).

ps Limit Care Costs Annually Per Hospice

patient care days limited
20 percent of the
ospice's total patient care
ays.

- Hospices receive higher rates for in-patient care than for in-home services.

- **Annual payment per beneficiary**
  - Hospice must repay the difference if total payments exceed its total numb of Medicare patients multiplied by th dollar cap amount set for each fiscal year.
  - Not adjusted for geographic differences in costs.
  - Adjusted annually by the medical expenditure category of the consum price index for all urban consumers.

ospice Payment History

spice per diem base payment rates set in 1983.

1983

- For each level of care.
- Based on **just 26 hospi**ces participating in a demonstration project.
- Potentially no longer align accurately with costs of providing hospice care.

ospice Payment History

983 to 1997:

- Hospice payments adjusted using 1983 wage index, based on 1981 Bureau of Labor Statistics data.

Y 1998:

- Hospice payments adjusted using prior fiscal year's pre-floor, pre-reclassified hospital wage index with a budget neutrality adjustment.

1983

1998

ospice Payment History

2010:

- Began phase-out of budget neutrality adjustment over seven years.
- Reduced by 0.4 percentage points in 2010.
- Reduced by additional 0.6 percentage points each subsequent year until eliminated in 2016.

1983

1998

2010

ospice Payment History

2016

Hospice Wage Index and Payment Rate Update final rule implemented on January 1, 2016:

- Bifurcated Routine Home Care for higher rate during first 60 days.
- Established Service Intensity Add-On for visits at end of life.

1983

1998

2010

2016

ospice Payment Rate Update FY 2020

sed on more recent and broader information gathering:

- Expanded Cost Reporting.
- Disparities reported between costs and payments.
- More information on claims.

sults:

- **Eliminates the one-year lag** of the pre-floor, pre-reclassified hospital wage index used to calculate the hospice wage index.
- **Increases hospice overall payment update percentage by 2.6 percent.**
- **Updates hospice cap amount.**

1983

1998

2010

2016

202

ospice Payment Rate pdate FY 2020

Updates to the hospice wage index, payment ates, and cap amount for fiscal year (FY) 2020.

- Rebases per diem payment rates, in a budget neutral manner to more accurately align payments with the costs of providing care, for:
  - Continuous home care (CHC).
  - General inpatient care (GIP).
  - Inpatient respite care (IRC).
- Decreases per diem payment rates for both levels of routine home care (RHC) to allow for budget neutrality.

Description	FY2020 MEDICARE Payment Rate	FY2020 MEDICAID Payment Rate
Routine Home Care (days 1-60)	$194.50	$194.75
Routine Home Care (days 61+)	$153.72	$153.92
Continuous Home Care Full Rate = 24 hours	$1,395.63 ($58.15 hourly rate)	$1,396.17 ($58.17 hourly rate)
Inpatient Respite Care	$450.10	$473.79
General Inpatient Care	$1,021.25	$1,021.25

*Failure to meet quality reporting requirements will result in a 2 percentag point reduction

Posted in NAHC ReportTagged Change Request 11411, FY2020 Hospice Ba Rates, FY2020 Hospice Payment Rule, Hospice, Medicaid, Medicare, Transr 4363

p Amounts for FY 2020

npatient care
ays remains at
0 percent of the
ospice's total
atient care days.

- **Annual payment per beneficiary**
  - Statutorily Mandated.
    - Cap amount for FY 2020 is $29,964.78
      - Calculated based on FY 2019 cap amount + 2.6 percent increase.
      - $29,205.44 + ($29,205.44 X 0.02 = **$29,964.78**

yment Reductions Still In Place FY 2020

equestration continues
o reduce payment by 2
ercent off the top.

ailure to report quality
nformation decreases
ayment by a further 2
ercent.

Public Reporting

ultiple Public Reporting Issues

spice Visits When Death Is Imminent Two-
m Quality Item Quality Measure Change.

spice Compare Update with Public Use File
ta.

PPERresources.org tells all about CMS' next
thing.

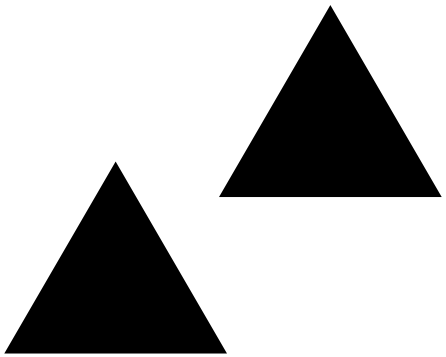
HPS volume-based exemptions to continue.

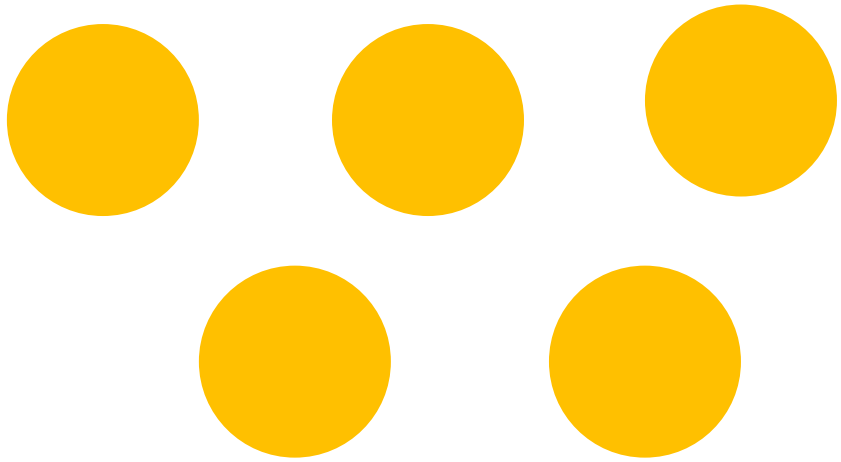
Hospice Visits When Death Is Imminent

spice Visits when Death is Imminent

mprised of two visit measures.

- “Paired” as each measures visits by hospice disciplines in the last days of life.
- Measure the numbers of visits performed by different hospice discipline groups.
- Unique measures that each provide useful and distinct information for separate public reporting.



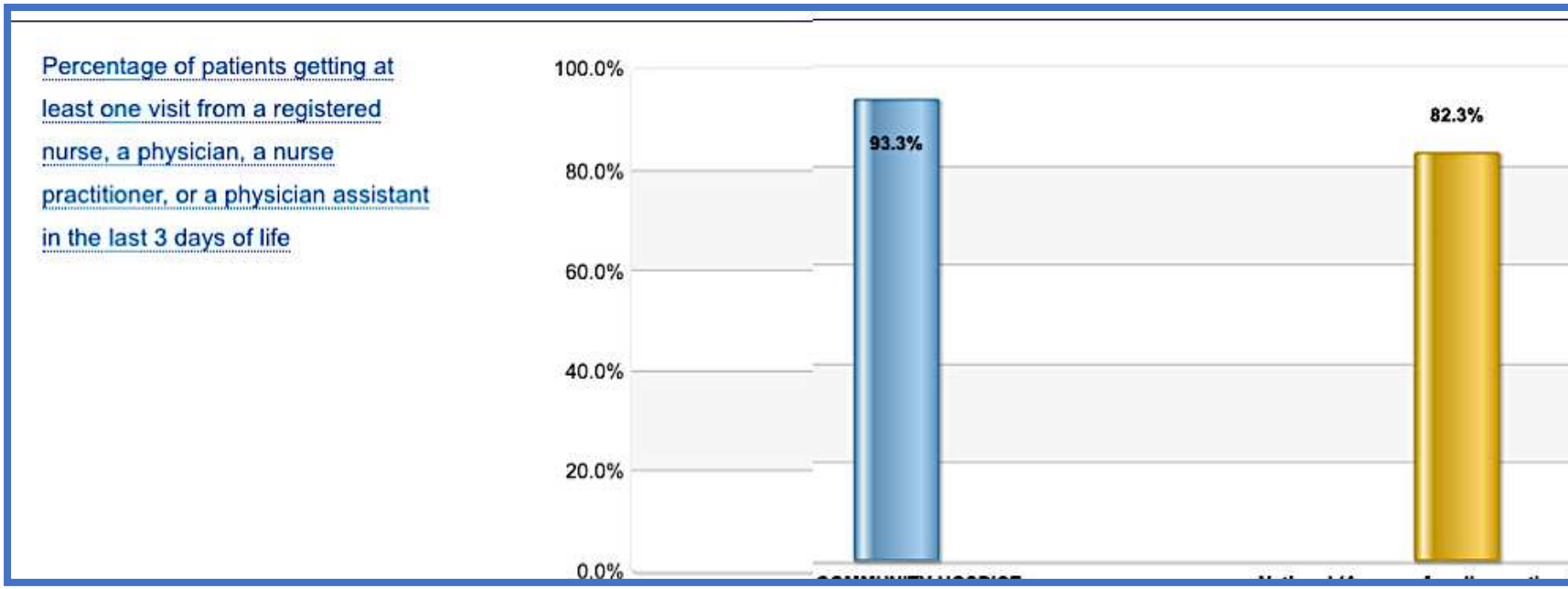


ospice Visits when Death is Imminent

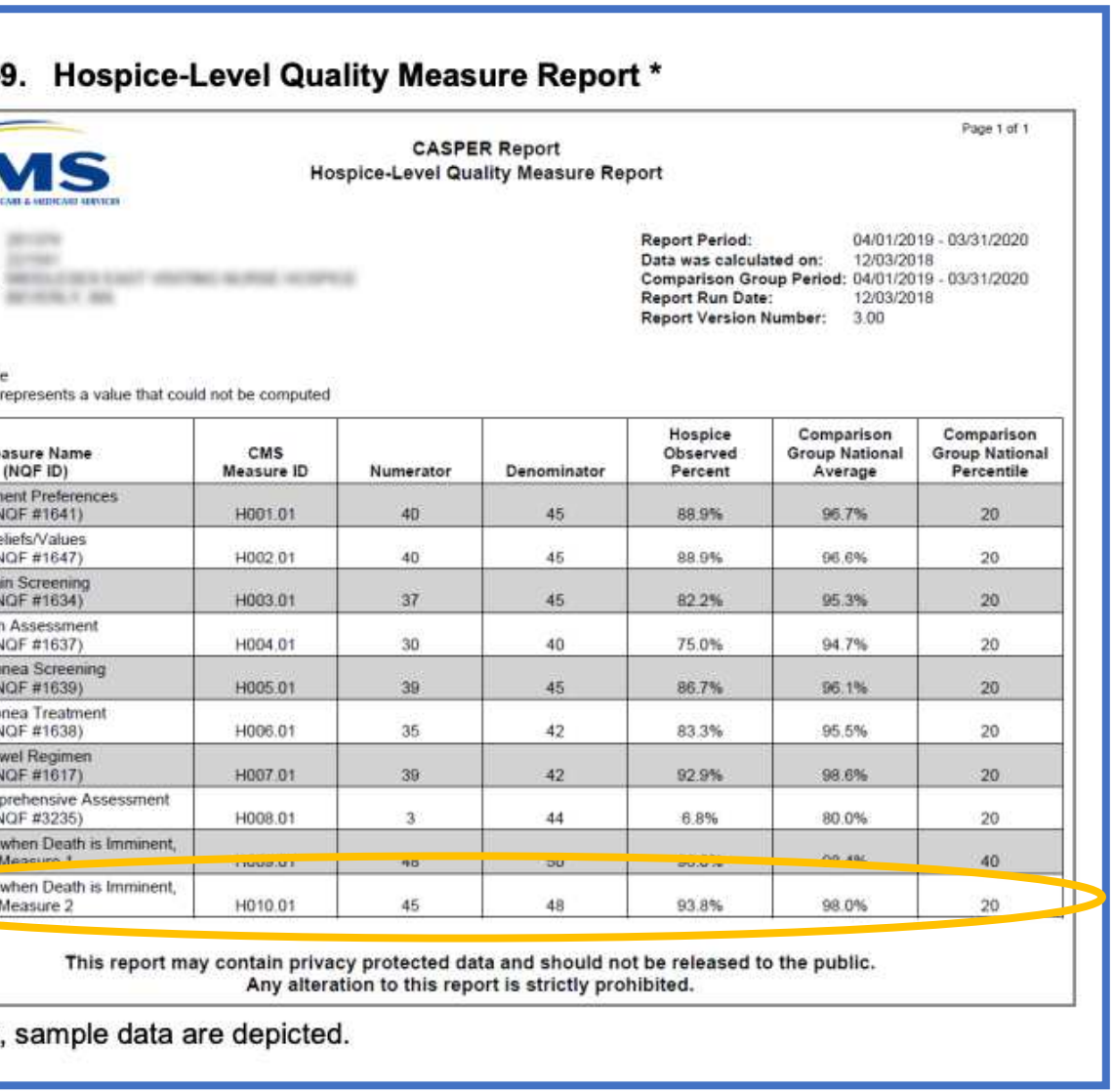
easure 1

Percent of patients received at least 1 visit from an RN, physician, nurse practitioner, or physician assistant in the last 3 days of life.

Meets established standards for reliability. Published on Hospice Compare.



asure 2 Available To Agencies Via CASPER



9. Hospice-Level Quality Measure Report *

Page 1 of 1

CASPER Report
Hospice-Level Quality Measure Report

[redacted]

Report Period: 04/01/2019 - 03/31/2020
Data was calculated on: 12/03/2018
Comparison Group Period: 04/01/2019 - 03/31/2020
Report Run Date: 12/03/2018
Report Version Number: 3.00

e
represents a value that could not be computed

asure Name (NQF ID)	CMS Measure ID	Numerator	Denominator	Hospice Observed Percent	Comparison Group National Average	Comparison Group National Percentile
ent Preferences NQF #1641)	H001.01	40	45	88.9%	96.7%	20
liefs/Values NQF #1647)	H002.01	40	45	88.9%	96.6%	20
in Screening NQF #1634)	H003.01	37	45	82.2%	95.3%	20
n Assessment NQF #1637)	H004.01	30	40	75.0%	94.7%	20
nea Screening NQF #1639)	H005.01	39	45	86.7%	96.1%	20
nea Treatment NQF #1638)	H006.01	35	42	83.3%	95.5%	20
wel Regimen NQF #1617)	H007.01	39	42	92.9%	98.6%	20
prehensive Assessment NQF #3235)	H008.01	3	44	6.8%	80.0%	20
when Death is Imminent, Measure 1	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	40
when Death is Imminent, Measure 2	H010.01	45	48	93.8%	98.0%	20

This report may contain privacy protected data and should not be released to the public.
Any alteration to this report is strictly prohibited.

, sample data are depicted.

- Measure 2
  - Percentage of patients receiving at least 2 visits fro social workers, chaplains or spiritual counselors, license practical nurses or aides in last 7 days of life.
  - Does not meet public reporting readiness standar Needs more testing.
  - Available by CASPER Repor for individual agencies' benefit.

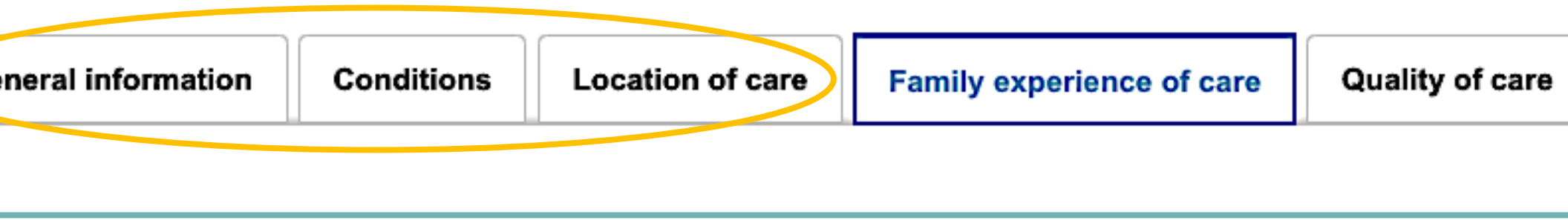
Hospice PUFs (Public Use Files)

blic Use Files on Hospice Compare

alized in the FY 2019 Hospice
al Rule:

Publicly post Public Use File (PUF) and other publicly available CMS data to the Hospice Compare Website

- Found in new sections on Hospic Compare to the left of tab entitl "Family experience of care."

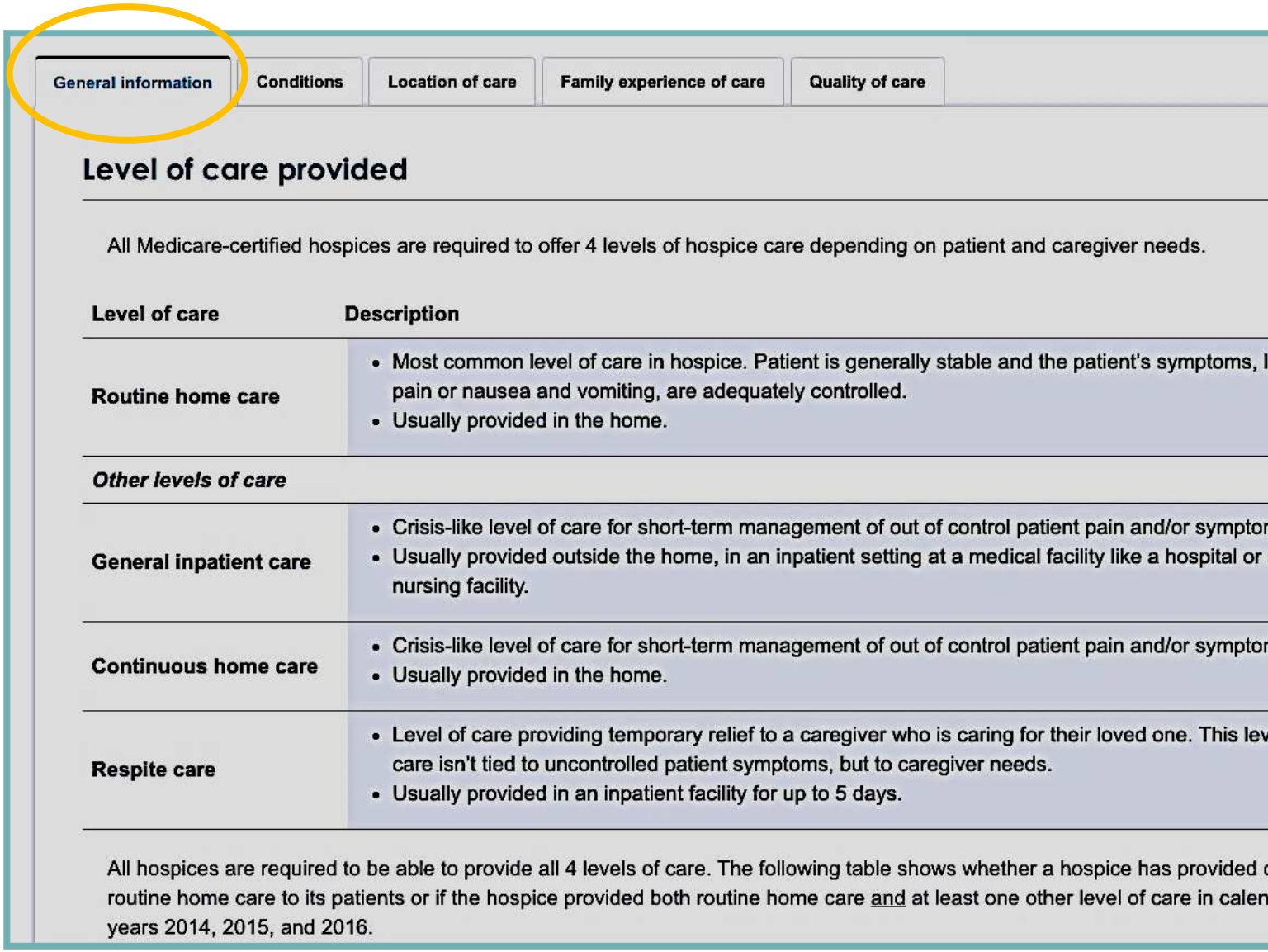


eneral Information Introduces PUF Content

eneral information”

Consumer-friendly format:

- States that all hospices must offer all four levels of care.
- Describes each level of care.



General information | Conditions | Location of care | Family experience of care | Quality of care

Level of care provided

All Medicare-certified hospices are required to offer 4 levels of hospice care depending on patient and caregiver needs.

Level of care	Description
Routine home care	• Most common level of care in hospice. Patient is generally stable and the patient's symptoms, l pain or nausea and vomiting, are adequately controlled. • Usually provided in the home.
Other levels of care	
General inpatient care	• Crisis-like level of care for short-term management of out of control patient pain and/or symptor • Usually provided outside the home, in an inpatient setting at a medical facility like a hospital or nursing facility.
Continuous home care	• Crisis-like level of care for short-term management of out of control patient pain and/or symptor • Usually provided in the home.
Respite care	• Level of care providing temporary relief to a caregiver who is caring for their loved one. This lev care isn't tied to uncontrolled patient symptoms, but to caregiver needs. • Usually provided in an inpatient facility for up to 5 days.

All hospices are required to be able to provide all 4 levels of care. The following table shows whether a hospice has provided routine home care to its patients or if the hospice provided both routine home care and at least one other level of care in calen years 2014, 2015, and 2016.

d The Hospice Provide More Than RHC?

ble below shows if hospice provides RHC only or also at least one more level.

All hospices are required to be able to provide all 4 levels of care. The following table shows whether a hospice has provided only routine home care to its patients or if the hospice provided both routine home care and at least one other level of care in calendar years 2014, 2015, and 2016.

Levels of care provided in calendar years 2014, 2015, and 2016	HOSPICE **Average daily census:** 104.7 **Date certified:** 12/15/1988	National average **Average daily census:** 74.8
Provided routine home care only		**3.1%**
Provided routine home care and at least one other level of care	✔	**96.9%**

Level of care is one of many things to consider when choosing a hospice. Patient and caregiver needs may impact the level of care a hospice provides. Additionally, hospices that see a small number of patients might not have patients that need a level of care besides routine home care. If you're considering a hospice that hasn't provided a level of care beyond routine home care in a 3-year period, talk to your doctor and/or hospice representative. For help having this discussion, see our Suggested Questions to Ask When Choosing a Hospice.

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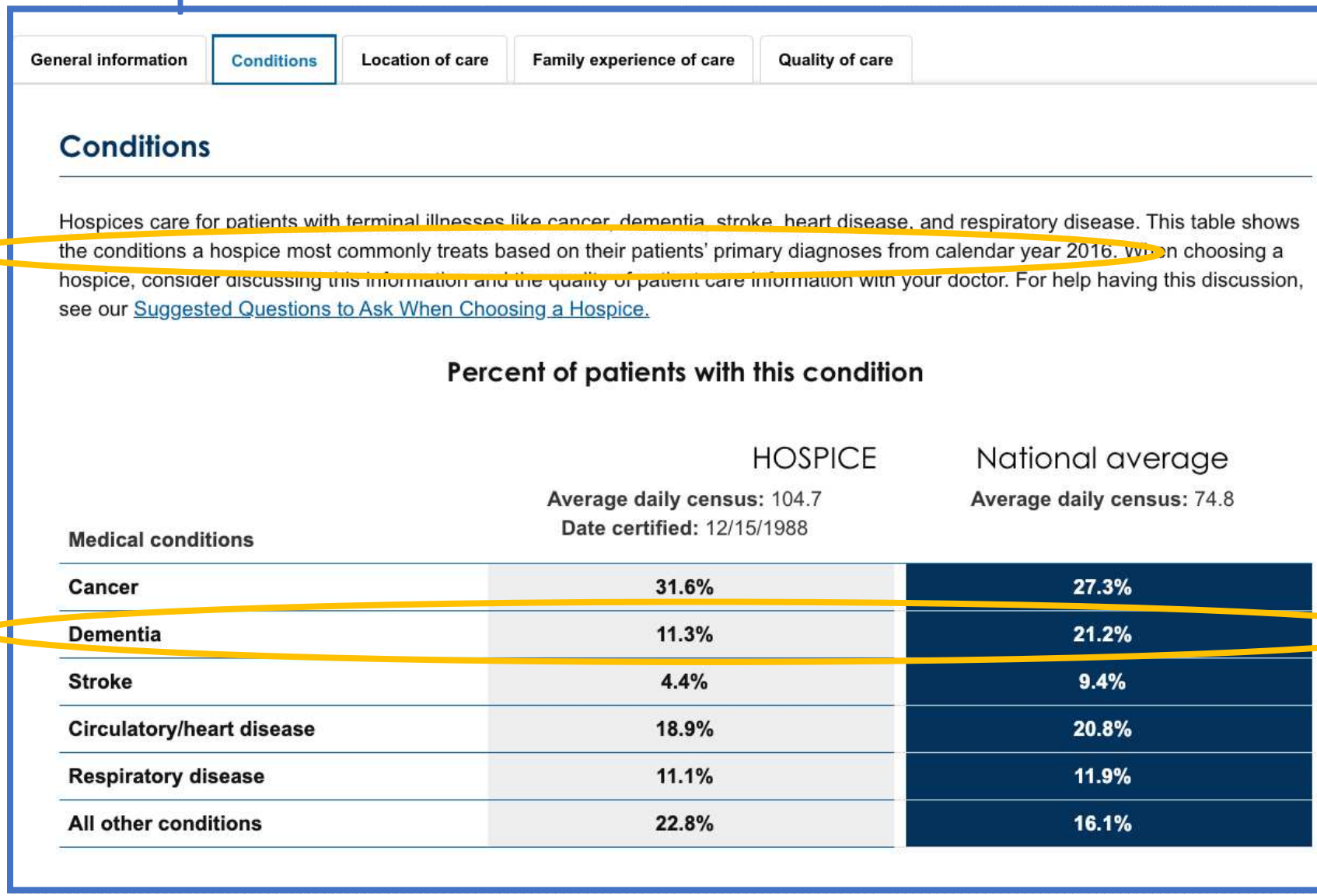


General information | Conditions | Location of care | Family experience of care | Quality of care

Conditions

Hospices care for patients with terminal illnesses like cancer, dementia, stroke, heart disease, and respiratory disease. This table shows the conditions a hospice most commonly treats based on their patients' primary diagnoses from calendar year 2016. When choosing a hospice, consider discussing this information and the quality of patient care information with your doctor. For help having this discussion, see our Suggested Questions to Ask When Choosing a Hospice.

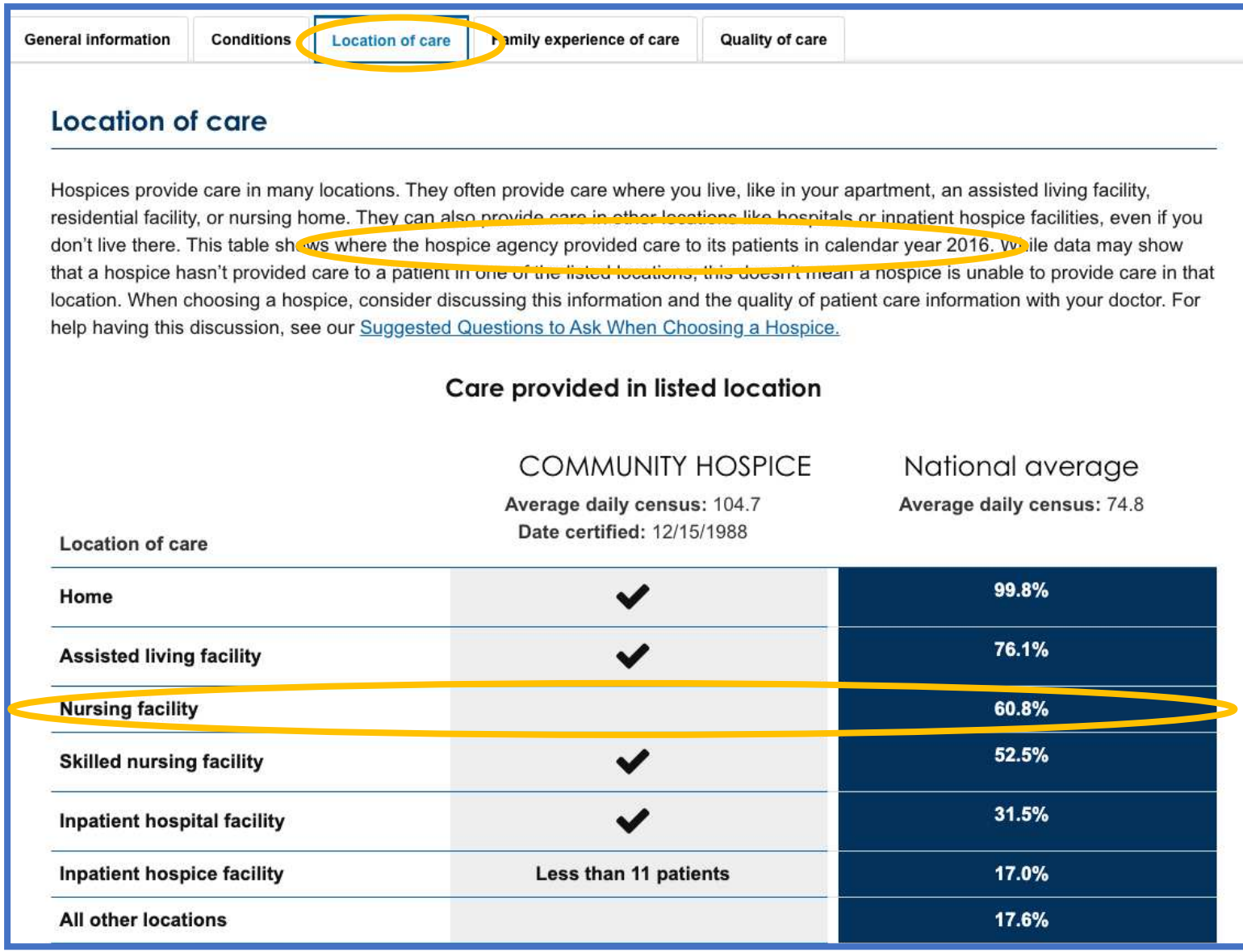
Percent of patients with this condition

Medical conditions	HOSPICE **Average daily census:** 104.7 **Date certified:** 12/15/1988	National average **Average daily census:** 74.8
Cancer	**31.6%**	**27.3%**
Dementia	**11.3%**	**21.2%**
Stroke	**4.4%**	**9.4%**
Circulatory/heart disease	**18.9%**	**20.8%**
Respiratory disease	**11.1%**	**11.9%**
All other conditions	**22.8%**	**16.1%**

e Hospice Agency Care Locations Typical?

ocation of care”

- Shows the percent nationally of care provided in each location and if the hospice provided care there during the time in question.
- Explains that not providing care at any location doesn’t mean the hospice can’t do so.



General information | Conditions | Location of care | Family experience of care | Quality of care

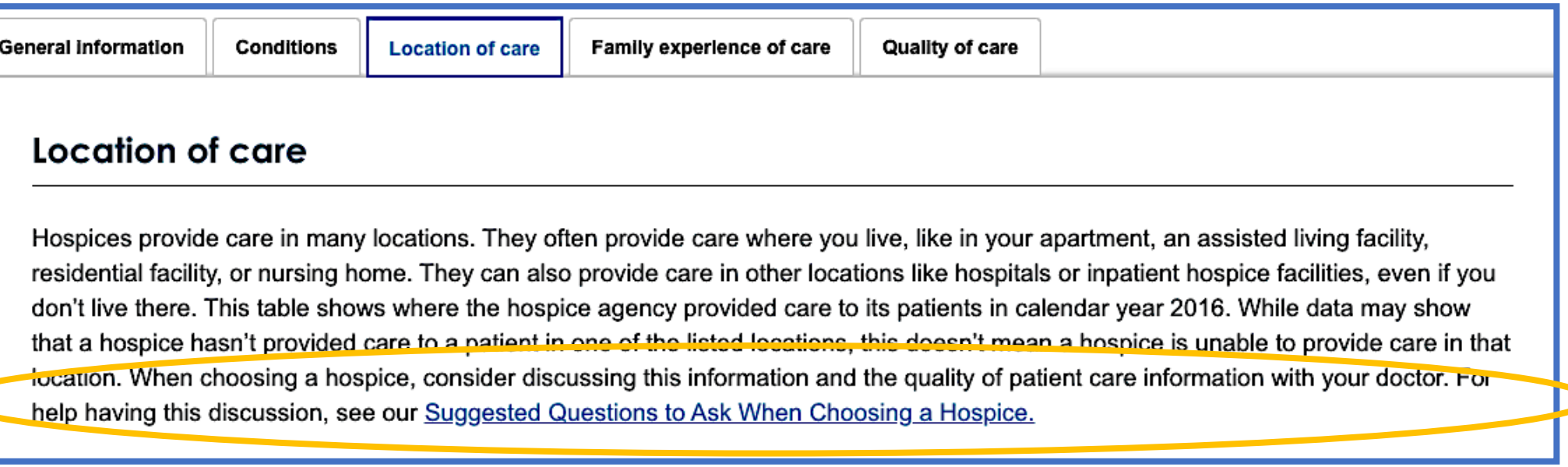
Location of care

Hospices provide care in many locations. They often provide care where you live, like in your apartment, an assisted living facility, residential facility, or nursing home. They can also provide care in other locations like hospitals or inpatient hospice facilities, even if you don’t live there. This table shows where the hospice agency provided care to its patients in calendar year 2016. While data may show that a hospice hasn’t provided care to a patient in one of the listed locations, this doesn’t mean a hospice is unable to provide care in that location. When choosing a hospice, consider discussing this information and the quality of patient care information with your doctor. For help having this discussion, see our Suggested Questions to Ask When Choosing a Hospice.

Care provided in listed location

Location of care	COMMUNITY HOSPICE **Average daily census:** 104.7 **Date certified:** 12/15/1988	National average **Average daily census:** 74.8
Home	✔	99.8%
Assisted living facility	✔	76.1%
Nursing facility		60.8%
Skilled nursing facility	✔	52.5%
Inpatient hospital facility	✔	31.5%
Inpatient hospice facility	Less than 11 patients	17.0%
All other locations		17.6%

courages Discussions With Physicians



Clear text in each explanation of the purpose and uses of Public Use File information.

Suggests consumers discuss this information with their healthcare provider.

orksheet To Guide Hospice Selection

Suggested Questions to Ask When Choosing a Hospice

To guide you and your family in finding hospice care, consider what's important to you and think about the questions below. This is not a complete list, but a way to start the conversation about the care you desire.

Overall program

- ☐ Does the hospice accept my insurance? What services and treatments will be covered?
- ☐ How long has the hospice been serving patients?
- ☐ Where are hospice services provided?
- ☐ Will the hospice provide a hospital bed and other medical equipment I might need?

Availability

- ☐ Will I have the same hospice nurse? What other members of the hospice team might I see, and how often will I see them?
- ☐ How many patients are assigned to each hospice nurse?
- ☐ Does the hospice have help after business hours? Nights? Weekends? Holidays?
- ☐ When I call with an urgent need, how long will it take for someone from the hospice team to respond?

Symptom management

- ☐ How will the hospice team manage my pain or other symptoms that arise?
- ☐ Can I take my current medications?
- ☐ What if my symptoms become uncontrollable at home? Can I go to the hospital?

Communication, coordination, and education

- ☐ How will the hospice team keep me and my family informed about my condition?
- ☐ Will my family and I be involved in making care decisions?
- ☐ How do I communicate any questions or concerns I have about my care?
- ☐ Can I still see my regular doctor if I am on hospice? If yes, how will the hospice team coordinate care with my doctor?
- ☐ How will the hospice team prepare me and my family for what to expect?

Caregiver resources

- ☐ Can we speak with other caregivers to learn of their experience with the hospice?
- ☐ What support services are offered by the hospice? What are our options if we need a break from providing care?
- ☐ What if we cannot take care of our loved one at home?
- ☐ How will the hospice team support us emotionally through the grieving process?

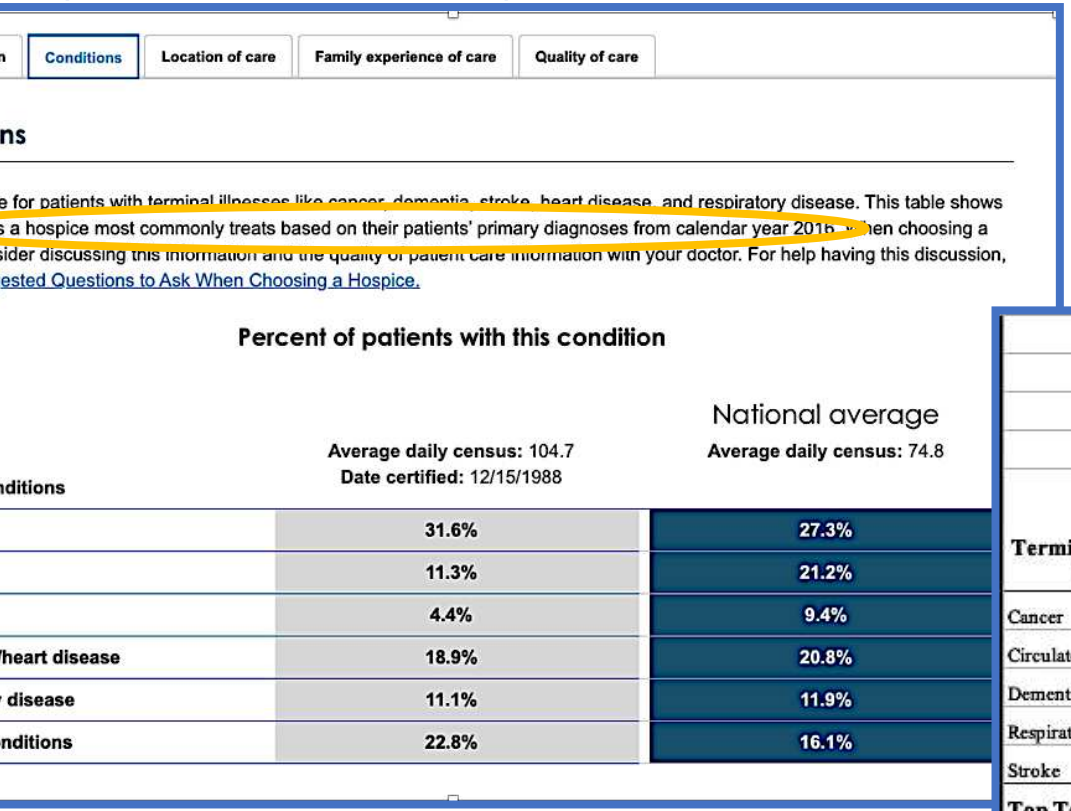
- CMS created a list of question consumers can use to help them choose a hospice agency that will meet their needs.

PEPPER

Program for Evaluating Payment Patterns Electronic Report

(An Agency's Best Friend)

spice Compare And PEPPERs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Percent of patients with this condition

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	4.4%	9.4%
heart disease	18.9%	20.8%
disease	11.1%	11.9%
nditions	22.8%	16.1%

pice Compare: CY 2016

ency-specific

PPER FY 2018: Decedent-specific

- Address common issues, unique tr
  - May capture helpful data trends.
  - Allows for correction before publis

Nationwide Top Terminal Diagnoses, Q4FY18

Decedents for most recent four quarters ending Q4 FY 2018

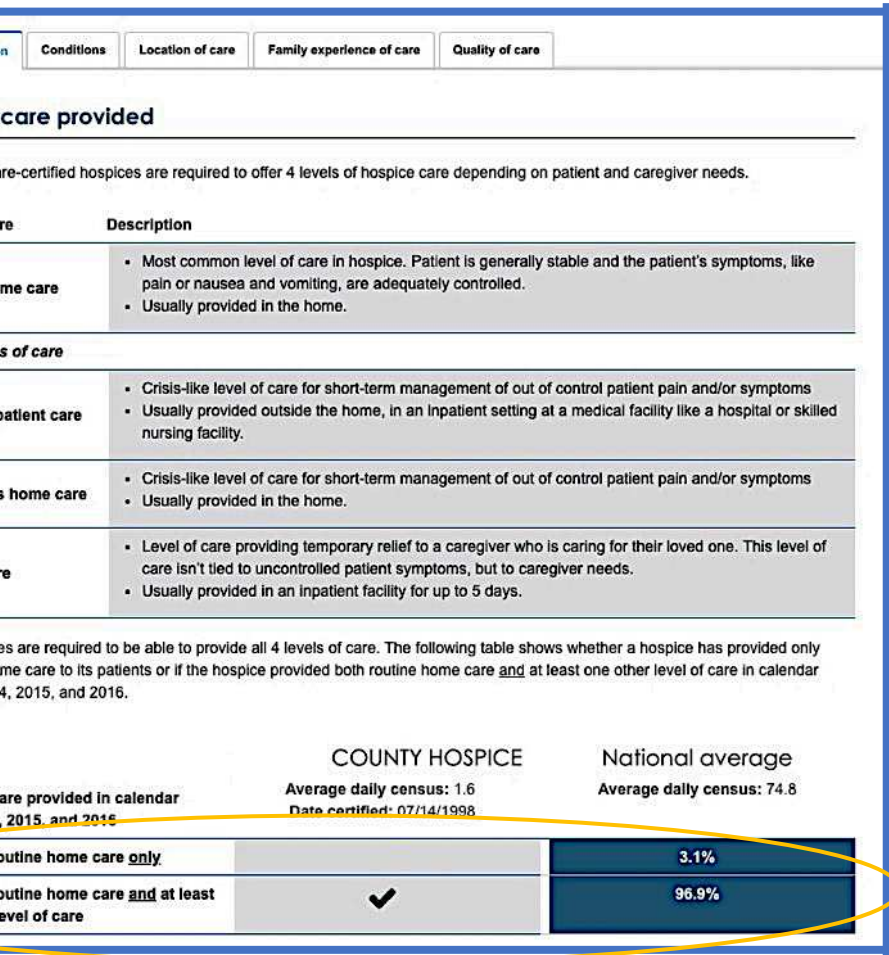
4,752 Hospices

In Descending Order by Total Decedents

Terminal Clinical Classification System (CCS) Diagnosis Category	Total Decedents for Each Category	Proportion of Decedents for Each Category	Nationa Length Cat
Cancer	329,384	29.6%	
Circulatory or heart disease	198,927	17.9%	
Dementia	174,701	15.7%	
Respiratory disease	122,197	11.0%	
Stroke	105,448	9.5%	
Top Terminal CCS Category	930,657	83.7%	
All CCS Categories	**1,111,773**		

Note: This report is limited to the top terminal CCS diagnosis categories for which there are a total of at least 11 decedents during the r fiscal year. The terminal CCS diagnosis categories are: Cancer (CCS categories 11-47), Circulatory or heart disease (CCS categories 9 114-121), Dementia (CCS category 653), Respiratory disease (CCS categories 127-134), and Stroke (CCS categories 109-113). The p 10 diagnosis code from the final claim was collapsed into a general category using Clinical Classification System (CCS) software. Mo information on CCS can be found at http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp. Average length of stay is calculated by d total number of days decedents received services from the hospice by the total number of decedents with the terminal CCS diagnosis c that received services from the hospice.

vels Of Care Focus



Conditions | Location of care | Family experience of care | Quality of care

care provided

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patient care	• Crisis-like level of care for short-term management of out of control patient pain and/or symptoms • Usually provided outside the home, in an inpatient setting at a medical facility like a hospital or skilled nursing facility.
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re	• Level of care providing temporary relief to a caregiver who is caring for their loved one. This level of care isn't tied to uncontrolled patient symptoms, but to caregiver needs. • Usually provided in an inpatient facility for up to 5 days.

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are provided in calendar , 2015, and 2016	COUNTY HOSPICE Average daily census: 1.6 Date certified: 07/14/1998	National average Average daily census: 74.8
outine home care only		3.1%
outine home care and at least evel of care	✔	96.9%

ressed differently by PEPPER and pice Compare.

Continuous Home Care in Assisted Living Facility		
Beneficiary episodes with 8+ hours CHC in an ALF	11,711	11,887
All beneficiary episodes in ALF	131,863	146,152
Proportion of Target to Denominator Discharges	8.9%	8.1%
Average Length of Stay for Target	161.6	163.2
Average Medicare Payment for Target	$29,890	$29,812
Sum of Medicare Payments for Target (in billions)	$.350	$.354
Routine Home Care in Assisted Living Facility		
RHC days in an ALF	17,458,191	19,237,806
All RHC days	98,252,458	103,078,441
Proportion of Target to Denominator Discharges	17.8%	18.7%
Routine Home Care in Nursing Facility		
RHC days in a NF	17,278,982	18,392,944
All RHC days	98,252,458	103,078,441
Proportion of Target to Denominator Discharges	17.6%	17.8%
Routine Home Care in Skilled Nursing Facility		
RHC days in a SNF	6,245,673	6,053,499
All RHC days	98,252,458	103,078,441
Proportion of Target to Denominator Discharges	6.4%	5.9%
Claims with Single Diagnosis Coded		
Claims with one diagnosis coded	639,066	533,498
All claims	4,479,231	4,699,302
Proportion of Target to Denominator Discharges	14.3%	11.4%
No GIP or CHC		
Episodes with no GIP or CHC	869,211	921,653
All episodes	1,204,875	1,259,064

CAHPS® Size Exemption Continues

hall Hospices Still Exempt From CAHPS®

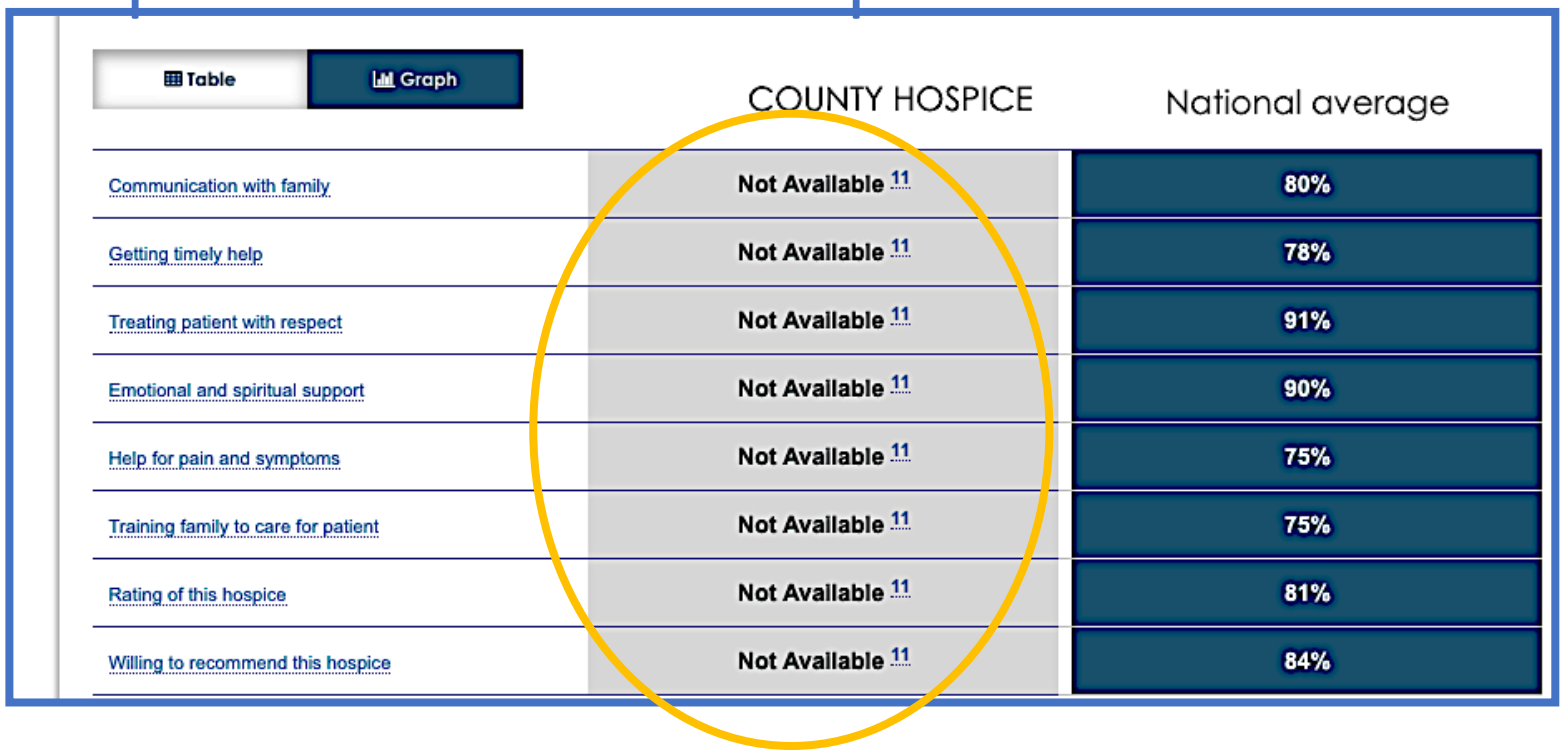


Table | Graph

	COUNTY HOSPICE	National average
Communication with family	Not Available [11]	80%
Getting timely help	Not Available [11]	78%
Treating patient with respect	Not Available [11]	91%
Emotional and spiritual support	Not Available [11]	90%
Help for pain and symptoms	Not Available [11]	75%
Training family to care for patient	Not Available [11]	75%
Rating of this hospice	Not Available [11]	81%
Willing to recommend this hospice	Not Available [11]	84%

Valid for hospices with fewer than 50 decedents during the year.

Please note, size exemptions are active for one year **only**.

- Hospices that meet continue meeting exemption criteria in any subsequent year must again request the exemption.

Hospice Outcome & Patient Evaluation (HOPE) Tool

OPE Tool Wins

Hospice Outcomes & Patient Evaluation Tool

- Hospice Evaluation Assessment Reporting Tool (HEART) was easily confused with the Hospice Abstraction Reporting Tool (HART).

HOPE, under development, to eventually to replace HIS to:

- Capture data with a hospice assessment instrument.
- Develop quality measures.
- Develop any future payment considerations to bridge the gap between payment and the cost of care.
- Increase understanding of patient care needs.

MS' Hopes for "HOPE" Tool

Other purposes of HOPE:

- Patient evaluation for hospices.
- Documentation more in line with other post-acute care assessment tools.
    - Keeping hospice's unique goals and outcomes in mind.

Future stakeholder input and information distribution to continue through rule making and sub-regulatory channels.

CMS:

- HOPE also provides the sentiment of hope for patients achieving the quality of life per their goals and wishes and supported by the hospice.

Election Statement Changes & Addendum (Effective Oct. 1, 2020)

CMS' Path to Election Statement Changes

e reasons are not new, people!

S keeps saying that hospices that must cover "virtually all care" f
pice-elected beneficiaries.

rug, or related or ed?

atients, family egiver can n informed bout whether ve hospice ney know rvices hospice ide.

neral view: The equired by law hospices to **virtually all the** is needed by y ill patients 5010).

Unrelated costs are rare.

In the FY 2020 hospice proposed rule, CMS reiterated the long-standing position that **services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare**.

Hospices not paying for all they should cover.

- Despite repeatedly published data on non-hospice spending for hospice patients, **hospices are basing coverage on a more narrow view of the overall condition of the individual** rather than providing comprehensive coverage as intended.

Beneficiaries, other providers need transparency.

- Anecdotal reports and the amount and nature of non-hospice-care spending suggest that **hospices don't fully inform beneficiaries of what** items, services and drugs **the hospice deems unrelated to their terminal illness and related conditions.**

Finalized electio statement chang & addendum.

- **Implementation postponed until C 1 2020** (FY 20021)
- Allow agencies to prepare.
- Allow CMS to work out with MACs the details concerning condition of payme requirement.

ection Statement Must Also Include:

nformation about the **holistic, omprehensive nature** of the Medicare ospice benefit.

A statement that, **although it would be are**, there could be some necessary tems, drugs, or services that will not be overed by the hospice because the ospice has determined that these tems, drugs, or services are to treat a ondition that is unrelated to the erminal illness and related conditions.

nformation about **beneficiary cost-haring** for hospice services.

4. Notification of the beneficiary's (or representative's) **right to request an election statement addendum** that includes a written list and a rationale the conditions, items, drugs, or servi that the hospice has determined to b unrelated to the terminal illness and related conditions.

5. **Availability of immediate advocacy** through BFCC-QIO (Beneficiary and Family Centered C are Quality Improvement Organization) if the beneficiary (or representative) disag with the hospice's determination.

w Addendum's Official Name:

atient Notification of Hospice Non-
vered Items, Services, and Drugs"

ka Election Statement Addendum)

atient Notification of Hospice Non-Covered Items, rvices, and Drugs" must include:

Name of the hospice;

Beneficiary's name and hospice medical record identifier;

dentification of the beneficiary's erminal illness and related conditions;

4. A list of the beneficiary's current diagnoses/conditions present on hos admission (or upon plan of care upd as applicable) and the associated ite services, and drugs, not covered by t hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions;

atient Notification of Hospice Non-Covered Items, rvices, and Drugs" must include:

- written clinical explanation, in anguage the beneficiary and his or her epresentative can understand, as to why the identified conditions, items, ervices, and drugs are considered nrelated to the terminal illness and elated conditions and not needed for ain or symptom management.

- This clinical explanation would be accompanied by a general stateme that the decision as to whether or conditions, items, services, and dru is related is made for each patient that the beneficiary should share t clinical explanation with other hea care providers from which they see services unrelated to their termina illness and related conditions;

atient Notification of Hospice Non-Covered Items, rvices, and Drugs" must include:

Eeferences to any relevant clinical ractice, policy, or coverage guidelines.

nformation on the following domains:
. *Purpose of Addendum*
. *Right to Immediate Advocacy*

8. Name and signature of Medicare hospice beneficiary (or representativ and date signed, along with a statem that signing this addendum (or its updates) is only acknowledgement o receipt of the addendum (or its upda and not necessarily the beneficiary's agreement with the hospice's determinations.

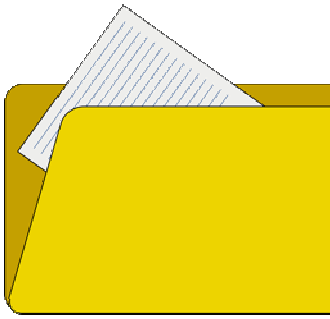
atient Notification of Hospice Non-Covered Items, rvices, and Drugs”

quired, as a condition of payment, for all hospice ctions.

- CMS acknowledges that no process is currently in place for MACs to check for addenda.
- separate release of information needed to provide tient Notification of Hospice Non-Covered Items, rvices, and Drugs to non-hospice providers.
- Effective way to show the hospice communicated with other providers.

atient Notification of Hospice Non-Covered Items, rvices, and Drugs”

rnish written copy to beneficiary only if the beneficiary or presentative requests the addendum.



- Within 5 days if requested at the time of hospice election.
  - Requirement met if beneficiary dies within 5 days of hospice election.
- Provide to beneficiary or representative within 72 hours from date of request if requested after the election date.

MS: It's Not About Hospice As "The Bad Guy"

mmenter: Addendum proposal makes spices look like "the bad guy" in nmunicating those items, services, and gs they have determined to be elated even if the hospice is providing s information in good faith.

- CMS: Disagree that the purpose of furnishing an addendum to communi hospice non-covered, unrelated items services, and drugs is to make the hos look like ''the bad guy''.

MS: It's All About The Beneficiary

S: Disagree that the addendum would
ve a ''chilling effect'' on hospice
nissions.

Information provided in the addendum will:

- Allow beneficiaries to make decisions to best meet preferences and goals of care.
- Mitigate unexpected need to seek services outside of the hospice and assume the associated cost-sharing.

- We believe beneficiaries and their families would appreciate full disclosu from the hospice as to what to expect when electing the Medicare hospice benefit.

lated Vs. Unrelated Conditions – Again

response to comments regarding ncerns about the vagueness of elatedness'' and requests for ditional CMS guidance as to what ''related'' and ''unrelated'', we mind commenters that since the plementation of the Medicare spice benefit, it has been our sition that **virtually all of the re needed by terminally ill lividuals should be provided by e hospice** (48 FR 56010).

- As such**, there should not be a voluminous list of unrelated ite services, and drugs** given the comprehensive nature of hospic services under the Medicare hospice benefit and the requirement that the hospice provide care addressing the physical, medical, psychosocial, emotional, and spiritual needs o hospice patients and families fac terminal illness and bereavemer

lated Vs. Unrelated Is Patient-Specific

MS:

In the FY 2015 hospice proposed rule (79 FR 26538) CMS solicited comments on definitions of ‘‘terminal illness and related conditions.’’

Many comments on these definitions.

Most commenters **opposed CMS proposing the definitions**.

- Comments from FY 2015 propos
  - **Hospices are experts** at mak such clinical determinations.
  - Statute and hospice regulatio allow for hospices to do so.
  - Hospice should establish a process to determine what is related and unrelated to the terminal illness and related conditions on a patient-by-patient basis.

uestions?

hank you.

Beth Noyce, RN, BSJMC

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and Home Health Consultant

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Utah Hospice and Palliative Care Organizat
2019 Convention, Sandy,