Key Issues in Hospice Policy:

The FINAL FY2020 Hospice Payment Rule and Implications for Hospice Practice

Webinar Q&A

August 8, 2019

Q: What percentage of days do the CHC and GIP comprise?
A: These figures can vary annually, but according to the proposed rule during 2018 routine home care (RHC) days totaled 98.2 percent of total hospice days. For the same time period, GIP days as a percent of total hospice days were 1.3 percent, IRC days as a percent of total hospice days were 0.3 percent, and CHC was 0.2 percent of total hospice days.

Q: When is the lag year going away?
A: Hospices are subject to the latest hospital wage index (the FY2020 wage index) for FY2020. The final wage index table is available here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices-Items/CMS-1714-F.html?DLPage=1&DLEntries=10&DLSort=3&DLSortDir=descending

Q: The following additions to the regulations do not state an effective date of 10/1/2020. Will they be effective 10/1/2019? 418.24 Election of hospice care. 418.24(b)(2) added the words “and related conditions” at the end of the sentence. 418.24(b)(3) added the following to the first sentence: that the individual has been provided information on the hospice’s coverage responsibility and”
A: The election statement modifications and the election statement addendum have an effective date of FY 2021 which is October 1, 2020. CMS stated “Therefore, we will finalize an effective date of FY 2021 for the election statement modifications and the addendum”.

Q: Is there data that supports agencies that have provided higher levels of CHC and GIP are audited at a higher level/more frequent basis?
A: Some Targeted Probe and Educate (TPE) reviews focus on higher utilization of the general inpatient (GIP) level of care.
Q: How can CMS make the addendum a condition for payment when it is a requested form by patient/caregiver?
A: CMS is making it a condition of payment that if the beneficiary/representative requests the election statement addendum it is provided by the hospice within the established timeframes and contains the required elements.

Q: On slide 28, it should read “...does NOT rise to the level of...” Is this correct?
A: Yes, this is correct. The full statement should be “Related to the clinical quality of health care but does not rise to the level of being a gross and flagrant, substantial, serious or urgent quality of care concern.

Q: What does QIO stand for?
A: It stands for Quality Improvement Organization.

Q: Would it be appropriate to use an ABN as the addendum?
A: No this would not be appropriate. CMS addressed this in the final rule in response to comments suggesting a modified ABN be used as the addendum. CMS states, in part: “The Advance Beneficiary Notice (ABN) is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service—FFS) beneficiaries in situations where Medicare payment is expected to be denied. The ABN is issued in order to transfer potential financial liability to the Medicare beneficiary in certain instances. The purpose the ABN is to inform beneficiaries of the listed items and services that Medicare is not expected to approve, and the specific denial reason (that is, not medically reasonable and necessary), whereas the proposed hospice addendum is intended to inform beneficiaries of items and services that the hospice will not cover as the hospice has determined them to be unrelated to the terminal illness and related conditions, and therefore, subject to coverage under other Medicare benefits.”

Q: What if patient rep makes a request at election, but then patient dies prior to the 5 days?
A: In this instance, CMS considers the requirement to have been met.

Q: If a non-covered item is on the addendum and is discontinued, are hospice agencies required to update for those changes as well?
A: CMS expects that if there are any changes to the conditions, items, services, and/or drugs listed on the addendum that occur after the hospice election and during the course of hospice care, the hospice would update the addendum accordingly and the beneficiary/representative would sign and date any updates. If there was a non-covered item that is discontinued, it would not necessarily mean an updated addendum is necessary if that item would still remain non-covered should it be used in the future. CMS may have more details on this in future rulemaking.