Arnall Golden Gregory LLP

AGG Hospice Quarterly

October 1, 2020 Hospice Changes: Hospices Must Provide Beneficiaries Addenda Outlining Conditions, Services, and Drugs Not Covered by Hospice

In an effort to increase coverage transparency, for hospice elections beginning on or after October 1, 2020, the beneficiary, beneficiary's representative, non-hospice providers, or Medicare contractors may request a written addendum to the election statement which outlines which conditions, items, services, or drugs are unrelated to the patient's terminal illness and related conditions.[1] The signed addendum and any signed updates are a new Medicare condition for payment. However, in issuing the rule, CMS clarified that this does not mean that the beneficiary needs to agree with the hospice's determination.[2]

Content of the Addendum

The election statement addendum must be titled "Patient Notification of Hospice Non–Covered Items, Services, and Drugs" and must include the following, among other information:

- A list of the beneficiary's conditions present 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.

- A written clinical explanation as to why the identified conditions, items, services, and drugs are considered unrelated to the beneficiary's terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation should be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs are related is made for each beneficiary and that the beneficiary should share this clinical explanation with other health care providers from which they seek items, services, or drugs unrelated to their terminal illness and related conditions.

- Language that immediate advocacy is available through the Medicare Beneficiary and Family Centered Care–Quality Improvement Organization (BFCC–QIO) if the beneficiary disagrees with the hospice's determination of non-coverage.[3]

The beneficiary or representative must sign the addendum as acknowledgment of receipt. However, a signature does not necessarily indicate the beneficiary's or representative's agreement with the hospice's determinations. When issuing the final rule, CMS recognized that there may be rare instances in which the beneficiary or representative may refuse to sign the addendum but did not provide further guidance addressing such situations.[4] The condition of payment is met if there is a signed addendum and any signed updates in the requesting beneficiary's medical record with the hospice, but the addendum is not required to be submitted routinely with each hospice claim.[5] Should a beneficiary or representative refuse to sign, we recommend the hospice document the date on which the addendum was provided and the reason for the refusal.

1 42 C.F.R. § 418.24.
2 85 F.R. 47087.
3 42 C.F.R. § 418.24(c).
4 85 F.R. 47087-47088.
5 85 F.R. 47087.

Timing

If the election statement addendum is requested at the time of initial hospice election, upon admission to hospice, the hospice must provide the addendum, in writing, to the individual within five days from the date of the election.[6] If this addendum is requested during the course of hospice care and after the hospice election date, the hospice must provide the addendum within seventy-two hours of the request. If there are any changes to the addendum during the course of hospice care, the hospice must update the addendum and provide these updates, in writing, to the individual.[7]

Other Changes to the Election Statement

In addition, hospice providers must make the following updates to the Election Statement itself to include the following:

- Notification of the beneficiary'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 and would not be covered by the hospice;
- Information on the BFCC–QIO, including the beneficiary's right to immediate advocacy and the BFCC–QIO contact information;
- 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 who has elected hospice; and
- Information on individual cost-sharing for hospice services.[8]

Note, while the addendum is only required to be furnished to beneficiaries, their representatives, non-hospice providers, or Medicare contractors who requested such information, the election statement modifications as outlined above apply to all hospice elections.

For more information, please contact H. Carol Saul or Charmaine A. Mech.

6 42 C.F.R. § 418.24(c). If a beneficiary requests the addendum at the time of hospice election and dies within five days from the start of the hospice election and before the hospice can furnish the addendum, the hospice would not be required to furnish such addendum after the patient has died. 85 F.R. 47088.
7 42 C.F.R. § 418.24(c).
8 42 C.F.R. § 418.24(b).

OIG to Initiate New Hospice Investigations and Audits

More than one year after two major hospice reports[1] raised concerns ranging from billing to patient safety, the U.S. Department of Health & Human Services Office of the Inspector General (OIG) continues its review of the hospice industry.

OIG will soon release reports addressing ways in which the hospice inpatient aggregate payment cap and payments made outside of the Medicare Hospice Benefit are calculated. The office is also reviewing specific providers' compliance efforts and Medicare payments for chronic disease management. In addition, OIG is investigating potential issues throughout various healthcare sectors that have come to light during the COVID-19 pandemic.

Last year's OIG reports garnered widespread attention and some criticism from the hospice industry. The first report indicated that approximately 20% of hospices surveyed by regulators or accreditors between 2012 and 2016 had at least one condition-level deficiency that posed a serious safety risk. A second report featured an in-depth discussion of twelve cases of alleged harm to hospice care beneficiaries with the goal of providing examples of vulnerabilities and prevention methods. OIG examined state agency and accreditor survey findings as well as complaint data from 2012 through 2016, which covered nearly all U.S. hospice providers.

Since releasing those reports, OIG has continued to monitor progress on its recommendations to the U.S. Centers for Medicare & Medicaid Services (CMS) for strengthening hospice oversight and reevaluating compliance measures. For example, CMS is making efforts to increase information available to healthcare consumers by featuring hospice complaint survey data on the Hospice Compare and the new Care Compare websites. CMS is also analyzing claims and deficiency data to improve the survey and complaint processes. OIG has also requested that CMS require hospices to report all instances of abuse or neglect, regardless of the responsibility or involvement of hospice staff.

For more information, please contact Jason E. Bring or Mary Grace Griffin.

1 U.S. Department of Health and Human Services Office of the Inspector General, OEI-02-17-0002, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries* (July 2019), *available at* https://oig.hhs.gov/oei/reports/oei-02-17-00020.pdf?utm_source=summary-page&utm_medium=web&utm_campaign=OEI-02-17-00020-PDF; U.S. Department of Health and Human Services Office of the Inspector General, OEI-02-17-00021, *Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm* (July 2019), *available at* https://oig.hhs.gov/oei/reports/oei-02-17-00021.pdf?utm_source=summary-page&utm_medium=web&utm_campaign=OEI-02-17-00021-PDF.

Hospice Payments Possibly Impacted by OIG Wage Index Recommendation

An August 2020 report by the U.S. Department of Health and Human Services Office of the Inspector General recommended that the U.S. Centers for Medicare & Medicaid Services (CMS) revamp its use of the hospital wage index to determine payments for health care providers. The hospital wage index is used, in conjunction with other information, to calculate hospice per diems paid by Medicare.

The proposed action was third on OIG's Top 25 unimplemented recommendations for 2020. Data from the hospital wage index data allows CMS to adjust payments to hospice providers in different geographic regions based on estimated labor costs. "OIG identified significant vulnerabilities in the wage index system for Medicare payments. For instance, CMS lacks authority to penalize hospitals that submit inaccurate or incomplete wage data, and Medicare administrative contractor (MAC)-limited reviews do not always identify inaccurate wage data," the report stated. "Additionally, wage indexes may not always accurately reflect local labor prices, thus Medicare payments to hospitals and other providers may not be appropriately adjusted to reflect local labor prices."

The recommendation's potential impact on hospice providers is uncertain. Because geography plays a role in payment calculations, some providers may benefit from increased payments while others could see payment reductions.

Importantly, an overhaul of the hospital wage index system by CMS would require congressional authorization. Legislators have not acted on OIG's recommendation, but the White House's proposed federal budget contains provisions for extensive revisions to the index.

The OIG report also provided updates on the implementation of previous recommendations made during the last two years that affect hospice providers. One recommendation was that provide consumers with additional information about hospices' performance via Hospice Compare. "CMS has published information from complaint surveys conducted by state agencies on its Quality, Certification, and Oversight Reports website. However, the information will not be posted on its Hospice Compare website," the report states. "CMS currently requires statutory authority to make public information from accrediting organizations on its websites. We note that the President's FY 2021 Budget includes a legislative proposal to allow CMS to make public survey results from accrediting organizations."

Last year, OIG recommended that CMS take steps to reduce perceived duplicate payments received by hospices for prescription drugs. OIG determined that some providers were billing Medicare Part D for medications that should have been covered through the Medicare Hospice Benefit, amounting to $160.8 million.

According to OIG, CMS has not yet addressed issue, saying that the agency believes that its current efforts would address the problem without disruption services to Medicare beneficiaries. CMS also does not plan to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit.

For more information, please contact Jason E. Bring or Mary Grace Griffin.

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