

PUBLICATION

Proposed Hospice Rule Focuses on Unbundling of Services [Ober|Kaler]

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On May 8, CMS released a [proposed rule](#) in the Federal Register providing for a payment increase of 1.3 percent for fiscal year (FY) 2015. Among other provisions, CMS's proposed rule offers hospice providers an update on hospice payment reform analyses conducted to date, solicits comments on the definition of "terminal illness" and "related conditions," and seeks to implement new processes to allow for enhanced communication and coordination between hospice providers and Part D sponsors in order to determine payment responsibility for drugs. Comments are due July 14, 2014.

A summary of key provisions in CMS's proposed rule is provided below:

- *Payment update:* Payments to hospice providers are set to increase by 1.3 percent in FY 2015. Overall payments by CMS to hospice care providers will increase by \$230 million.
- *Hospice payment reform analyses:* Recent analyses of hospice payment data conducted by CMS contractors strongly suggest, according to CMS, that hospice services are being "unbundled," shifting costs to other parts of Medicare and increasing the cost sharing responsibilities of hospice beneficiaries. While not specifically soliciting comments on its analyses, CMS noted its intent to continue to monitor non-hospice Medicare spending for those patients receiving the hospice benefit.
- *Definition of "terminal illness" and "related condition":* In response to comments received from the hospice community following the release of several CMS memoranda related to Part D payments for hospice beneficiaries, CMS requested comments on the definition of both "terminal illness" and "related condition." Notably, and contrary to comments it had previously received from the hospice community, CMS reiterated its current belief that longstanding, preexisting conditions are in fact related to a patient's terminal illness, and that chronic, stable conditions play a meaningful role in a patient's terminal illness or related conditions.
- *Hospice cap determinations—new reporting timeline:* Noting that an increasing number of hospices are exceeding their aggregate cap, CMS proposed to require that all hospices complete their inpatient and aggregate cap determinations within five months after the cap year end, and remit any overpayments at that time. CMS Medicare Administrative Contractors (MACs) currently complete hospice cap determinations 16 to 24 months after the cap year.
- *Filing the notice of election (NOE) and the notice of termination/revocation (NOTR) – new reporting timelines:* CMS is seeking to impose more stringent NOE and NOTR filing requirements. CMS has proposed requiring all hospice providers to file a hospice beneficiary's NOE with its MAC within three calendar days after the effective date of the hospice election. Similarly, CMS proposed that NOTRs must be filed within three calendar days after the effective date of a beneficiary's discharge or revocation.
- *Coordination of benefits process and appeals for Part D payments for drugs:* Prior CMS guidance reiterated its stance that Part D plan sponsors may only pay for hospice beneficiary drugs when the drug is unrelated to the beneficiary's terminal prognosis or its related conditions. It also required Part D plan sponsors to place beneficiary-level prior authorization (PA) requirements on all drugs for hospice beneficiaries submitted to Part D sponsors. In response to comments requesting that CMS clarify both (1) how to determine payment responsibility between the hospice benefit and the Part D sponsor; and (2) the logistics of the prior authorization process, CMS has now solicited comments on how best to facilitate the coordination of payment between Part D sponsors and hospices.

In addition to the above key provisions, CMS has proposed (1) to require that all hospice election forms include the attending physician's name, (2) to update the hospice quality reporting program, and (3) to implement several technical regulatory changes.

Ober|Kaler's Comments

CMS's proposed hospice rule is notable for its heavy emphasis on addressing concerns that hospice services are currently being “unbundled” by hospice providers, i.e., that hospice providers are shifting costs to Medicare Parts A, B, and D that are otherwise the responsibility of hospice providers. Accordingly, it is important for hospice providers to assess (1) the degree to which their hospice beneficiaries' have conditions not related to the terminal illness or its related conditions; and (2) their current documentation practices, upon determining patient care costs are not associated with the patient's terminal illness and its related conditions. CMS is clearly aiming to curtail such billing practices.