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CMS Finalizes 2020 Hospice Rule: Big Changes Coming

SheppardMullin

Article By
Brian M. Daucher
Sheppard, Mullin, Richter & Hampton LLP
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On August 6, 2019, CMS finalized its 2020 hospice rule, including adopting, without substantial modification, two controversial and material changes to the hospice benefit:

- Rebasing payment rates to shift about $500 million from routine care to enhanced levels of care including general inpatient, continuous, and respite care.
- Adopting a requirement that, upon request (either at admission or later), hospices disclose in an extensive written addendum to patients (and other health care providers) any care that would be deemed unrelated to hospice care.

We reviewed these proposals in detail in prior blogs posts on rebasing and unrelated care disclosures; and, we submitted these comments to CMS. In this blog, we will note the changes that CMS did make to these proposals and note some of the potential effects.

CMS adopted payment rebasing without substantial change. The result is a reduction of approximately $5 per day for routine home care, with those funds (about $500 million) re-allocated to increase enhanced levels of care. This reduction, however, is substantially offset by a 2.6% payment increase this year. Taken together, this means that hospices will be paid about the same next year as this year for routine home care.

Although this could seem to be a no harm / no foul situation, the potential problems are as follows: (a) with increased GIP rates, these rates will simply be a net transfer

to hospitals, while at the same time pushing hospices toward the cap sooner; and (b) perhaps of more concern, this change enshrines CMS' assumption (which we regard as false) that routine home care days are substantially overpaid. At its core, these changes reflect a subtle contempt for the day in / day out work that hospices do to serve patients outside of enhanced contexts; given that routine days are 97% of the days hospices provide, it is a problematic message, and portends future risk (cuts in routine home care rates) for the benefit.

With respect to the unrelated treatment addendum, CMS did make a few changes of note: (a) CMS deferred implementation by one full year until fiscal year 2021, to allow providers time to prepare policies and forms; (b) CMS extended timelines for delivery of the addendum, now allowing 5 days on admission or 72 hours at any other point during treatment for delivery of the addendum; and (c) CMS has excused provision of the addendum if the patient passes away in the first 5 days of care.

CMS refused to accede to provider requests to implement the addendum requirement as something less than a "condition of payment," thereby reserving the right in theory to deny all payment to any provider found in fault of this provision for a specific patient.

CMS declined to respond directly to this space's comment that audit denials should be limited to cases where the patient or Medicare actually incurred expense due to unrelated care. Instead, CMS acknowledged concern about audit risk, stating that "to assuage commenter concerns ... we will collaborate with the MACs to establish clear guidelines on the use of the addendum as a condition for payment and we will propose any requirements in future rulemaking if necessary." If anyone can discern in this an actual commitment from CMS to be fair, their powers of perception exceed ours.

It remains the view of this space that any audit denial of payment due to fault on this requirement should be *proportional to some actual harm* (unrelated care expense incurred by patient or Medicare), rather than a wholesale forfeiture of payment for all services rendered to the patient. In every other aspect of the American legal system, the law famously "abhors a forfeiture." Even punitive damages, given for the worst conduct, must be proportional to harm to be constitutional (10 times harm is the *de facto* constitutional limit). Medicare and its auditors should not be permitted to exceed this standard.

Over objection, CMS insists that the addendum will only take "10 minutes" for a nurse to prepare (and therefore imposes only "minimal" burden on providers). Yet, CMS notes that any addendum must include a list of 8 items, including "a written clinical explanation" supporting a determination that certain care is unrelated (an explanation that will no doubt be scrutinized by auditors); in addition, providers must somehow secure a patient signature on these addenda (ignoring the problem that many hospice patients are signed into hospice by patient representatives who are not always readily available after election). 10 minutes to do all of this? When journalists and MedPAC and OIG bemoan the "corporatization" of hospice, moments like this should be remembered. Incrementally, rule by rule, audit by audit, CMS has dictated this result.

One further question promises to be of interest in all of this: How will we

understand the complex relationship between care which is curative (and hence excluded / waived by the hospice election), care which is palliative, related, and hence covered, and, finally, care that is not curative but also unrelated to hospice and hence *still allowed under Medicare*? There has always been tension in the hospice benefit, and reticence in patients to elect, stemming from the waiver of curative treatment.

Now with the requirement to disclose (what may be the relatively rare problem of) unrelated care (but not curative care that is waived), patients, patient representatives, and providers will have to have a more nuanced understanding of this complex nexus. Patients and their families do not come to hospice with expertise in these matters; instead, when they approach hospice they are facing the loss of a loved one; and, CMS itself is unwilling to draw any bright lines, instead once again putting that burden on the hospices themselves.