FAQ about the 2024 hospice proposed rule

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On Friday, March 31, 2023, the U.S. Centers for Medicare & Medicaid Services (CMS), released the proposed payment rule for hospice providers for fiscal year (FY) 2024. It includes a proposed update to hospice payments by 2.8%, which would increase hospice payments by $720 million (compared to the FY 2023 payments). In addition, there are important proposed updates to the Hospice Quality Reporting Program (HQRP), the hospice certification process, the Hospice Outcomes and Patient Evaluation (HOPE) tool, and more.

WellSky hospice regulatory expert Katherine Morrison, RN, MSN, CHPN, presented an informational webinar that covered key elements of the proposed rule and explored the changes your team should understand as you prepare for 2024; that webinar is now available to watch on-demand. The 2024 hospice proposed rule is an important opportunity to look into the near future of hospice care and to consider the impact of the proposed changes. **In this tip sheet, Katherine answers the most frequently asked questions about the hospice proposed rule.**

Q: Due to the ongoing staffing shortages that our hospitals are dealing with, we haven't had success getting respite or general inpatient care (GIP) beds for hospice patients. How can we deal with this problem?

A: The Conditions of Participation (CoPs) allow hospices to work with skilled nursing facilities to provide inpatient respite care or general inpatient care through contract. Other options include contracting with another hospice provider that has an inpatient unit to contract beds or to build a pool of relief nurses to support continuous home care (CHC). Be sure to document your attempts at securing contracts and any refusal of acceptance to share with surveyors.

Q: What is a targeted probe and educate?

A: In CMS' own words: *"CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help. It is intended to increase accuracy in very specific areas. The Medicare Administrative Contractors (MAC) use data analysis to identify providers and suppliers as well as items and services that have high claim error rates, unusual billing practices, high national error rates and financial risks to Medicare. Chosen agencies will receive a letter from the*

MAC who reviews 20-40 claims and supporting records for compliance. If found to be non-compliant or have low accuracy in claims additional claims will be reviewed up to 3 rounds of review and educational sessions. After 3 rounds, the agency can be referred to CMS for next steps that could include prepay review, extrapolation, referral to a recovery auditor or other action."

 See additional information here.

Q: Does CMS expect the hospice to pay for dialysis by suggesting it is a palliative measure? Most hospices cannot afford the cost including transportation.

A: In this hospice proposed rule, comments were made around the utilization of hospice for end-stage renal disease (ESRD) and chronic kidney disease (CKD) patients, as noted by CMS and some members of U.S. Congress. There was no rule stating that hospices must cover these costs; however, this examination by CMS will likely continue. CMS is currently evaluating the Kidney Care Choices (KCC) Model through its Innovation Center, which is focused on creating coordinated and seamless care. This includes examining concurrent care for beneficiaries who elect the Medicare hospice benefit, and it would waive the requirement that beneficiaries elect to forgo curative care as a condition of hospice services. This model will continue through December 13, 2026, and may provide further evidence to CMS on how best to serve this population of patients. Research shows that an approach that allows for both services — dialysis and hospice — leads to timelier hospice service and better alignment with patient and family preferences.

 See additional information here.

Q: Hospice agencies have found communicating with Part D providers to be very difficult. We have tried working with local pharmacies as well as our pharmacy benefit manager (PBM) to obtain direct contact numbers for the non-covered medication forms to be sent, but we have not been successful. Where are other agencies sending these requests to, in efforts to pay for medication upfront as a hospice? Part D providers never responded to our needs, and we have not been successful in speaking with them.

A: Often hospices are left paying back money upon an audit by Part D providers. Others have implemented processes at admission (when the plan of care is developed) to verify with the PBM what meds are covered and non-covered. As part of the contract, providers have indicated that the four areas of expectation for medication coverage (analgesics, anxiolytics, anti-nauseants, and laxatives) are automatically a covered item unless an exception is communicated. Finally, some hospices have implemented processes to review medication coverage monthly, and then at discharge or death, to fax an updated list of covered/non-covered lists.

Q: The use of virtual options for face-to-face (F2F) encounters has CMS and our intermediary in conflict. Each says something different about the end date. One says May 11 and the other says December 31, 2023. Please advise.

A: The use of telehealth for patients receiving routine home care was an interim regulatory change and will expire with the end of the PHE or May 11, 2023. The use of telehealth for the F2F encounter was extended through December 31, 2024, via the Consolidated Appropriations Act of 2023 Section 4113(f). This act extends the authority for hospices to conduct F2F visits via telehealth using two-way audio and video communications. Also see CMS publication "Hospice: CMS flexibilities to fight COVID-19" published on May 10, 2023. CMS proposes to codify this change in the FY 2024 proposed rule by changing the language at 418.22 (a)(4)(ii) to add "or through December 31, 2024, whichever is later."

Q: What's the status on Medicare Advantage and a carve-in for hospice payment?

A: The Medicare Advantage Value-Based Insurance Design (VBID) demonstration has been extended to 2030. The extension for 2025-2030 will introduce changes to more fully address recognition of social determinants of health, advance health equity, and improve care coordination for patients with serious illness. Under the model extension, beginning in 2026, participating Medicare Advantage Organizations (MAOs) will have more flexibility to require enrollees to only receive hospice services from in-network hospice providers, as long as the MAOs meet CMS' qualitative and quantitative network requirements.

 See additional information here.

Q: What costs are generally associated with Part B billing in the home setting? And if mobile physician services are included in this, and they are incorrectly stating patient is in a home versus the assisted living, how can a hospice report this to Medicare as an error?

A: When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services related to the treatment and management of the terminal diagnosis and all related illnesses during any period of the hospice benefit election, except for professional services of an attending physician (which may include a nurse practitioner). Costs associated with Part B that could be

attributed to the hospice are items like laboratory testing, X-rays, and associated professional components of those services. The hospice should ensure payment for those services related to the terminal diagnosis and all related illnesses are billed to the hospice and not Part B. Any errors in claims should be reviewed with the Medicare intermediary.

Q: When patients seek emergency care or other care without prior approval from the hospice, is there still an expectation for the hospice to cover those charges?

A: On the Medicare.gov website, they note: "Medicare **won't** cover any of these once your hospice benefit starts: […] **Care you get as a hospital outpatient (like in an emergency room), care you get as a hospital inpatient, or ambulance transportation**, unless it's either arranged by your hospice team or is unrelated to your terminal illness and related conditions. Contact your hospice team before you get any of these services or you might have to pay the entire cost."

Be sure to document the education provided and patient/family/caregiver understanding of said education. If the reason for emergency care or hospitalization is related to the terminal diagnosis, and documentation shows poor management of pain or symptoms requiring more aggressive palliative treatment, your MAC may determine this to be a hospice-covered expense and the hospice liable for costs.

Q: What does SFP stand for, and can you please explain this program?

A: The Special Focus Program (SFP) was mandated under the Consolidated Appropriations Act, 2021, where hospices identified as "poor performers" would be monitored based on quality indicators. In the calendar year (CY) 2022 Home Health Prospective Payment System Final Rule, CMS established a technical expert panel (TEP) to further develop the methodology to identify hospice "poor performers" for the SFP, as well as graduation and termination criteria and public reporting. Watch for the implementation proposal for the SFP in the CY 2024 Home Health Prospective Payment Update Rate proposed rule.

See additional information here.

Q: What is the requirement for submission of the quality reporting to meet compliance?

A: To comply with CMS' quality reporting requirements, the hospice must submit the timeliness compliance threshold (defined as 90 percent of all required Hospice Item Set (HIS) records) within 30 days of the patient's admission or discharge. Ninety percent of all required HIS records must be **submitted and accepted** within the 30-day submission deadline to avoid the statutorily mandated payment penalty. For CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey utilizing a CMS-approved third-party vendor.

Q: There seems to be a lot of attention on live discharges. What are we supposed to do when patients no longer meet the terminal criteria?

A: The attention currently being paid to live discharges is multifactored. CMS is evaluating if the increase in live discharges is related to integrity issues. For example, practices such as "encouraging" patients to revoke the hospice benefit to avoid paying for expensive treatments or when the hospice is close to its cap payment amounts. There are also questions around whether hospices provide adequate care when higher levels of care are indicated. CMS is looking at long lengths of stay (LLOS) where agencies may accept patients into care too early and they may not fully meet terminal eligibility creating those LLOS. Patients and families may not fully understand the hospice benefit — where they waive other benefits and elect hospice services only to revoke the benefit later when they want treatment. CMS is suggesting that hospices have some work to do in order to ensure regulatory compliance by providing informed consent, demonstrating terminal eligibility, offering all services covered in the hospice benefit, and providing quality care.

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Text - H.R.2617 - 117th Congress (2021-2022): Consolidated Appropriations Act, 2023. (2022, December 29). https://www.congress.gov/bill/117th-congress/house-bill/2617/text

About the author

Katherine Morrison, RN, MSN, CHPN, is the Director of Hospice Consulting Operations. Katherine has worked in hospice for over 20 years, most of which was spent in leadership roles. She holds a Master of Science in Nursing with a major in nursing informatics. Her experience includes leading home hospice programs as well as freestanding hospice residences. She is an ELNEC trainer and has presented the ELNEC curriculum to organizations of all sizes. She is a member of numerous industry organizations and is committed to excellence in end-of-life care.

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