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No Addendum, No Payment

Mastering the New Mandatory Hospice Election Statement Addendum

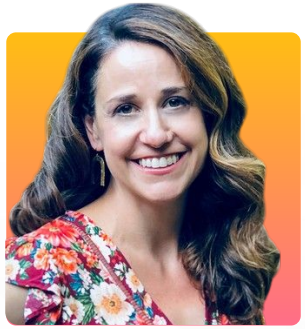
FY 2027 Hospice Final Rule (CMS-1851-F, 91 FR 49118) · 42 CFR 418.24

11/04/2026

Today's Speakers



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What You Will Be Able to Do After Today

1. **Explain the change**
   State what the addendum is, who gets it, and what changed on October 1, 2026.
2. **Meet the deadlines**
   Apply the five-day furnishing clock and the three-day update clock, and know when they stop.
3. **Do it at the bedside**
   Complete, explain, sign, document, and file the addendum on every Medicare admission.

The Change in One Slide

BEFORE · Elections before 10/01/2026

- Addendum provided ONLY when someone asked for it
- Patient, representative, non-hospice provider, or Medicare contractor had to request it
- A small fraction of admissions
- Election statement told the patient they had a right to request it

NOW · Elections on or after 10/01/2026

- Addendum provided on EVERY Medicare hospice election
- No request needed; we furnish it because they elected hospice
- 100% of Medicare admissions, every time
- Election statement and packet updated to match what we actually do

The rules did not change nearly as much as how often we have to follow them.

Why CMS Made This Mandatory

$2.8B

Medicare non-hospice spending during a hospice election, FY 2024 (Parts A, B, D)

160%

Growth in non-hospice Part A and B spending from FY 2020 to FY 2024

67%

Of non-hospice spending that occurred after election day 60

CMS concluded the on-request model was not creating accountability. Since 1983 the expectation has been that virtually all care needed by a terminally ill patient is provided by the hospice—care outside the benefit should be exceptional and unusual. The addendum is how that determination becomes visible to patients, other providers, and reviewers.

Who Gets an Addendum

YES	Every Medicare beneficiary whose election is effective on or after October 1, 2026—even when all medications/services are covered!
YES	Any patient who revokes and reelects, or transfers to us, on or after October 1, 2026—that is a new election.
NO	Patients already on service under an election that began before October 1, 2026—they stay under the old on-request rule.
NOTE	A new benefit period is NOT a new election. The election continues as long as the patient stays with us, does not revoke, and is not discharged.

The Two Clocks You Have to Know

Five Days to Furnish

The clock starts on the election effective date, as “day zero”. Provide the addendum in writing to the patient or representative at the time of election, or within the first five days, and file it with the election statement in the medical record.

Three Days to Update

The clock starts at any plan-of-care change that affects a coverage determination. Update the addendum, give the update in writing to the patient or representative, and update the copy on file.

The date there is a plan-of-care change affecting the addendum is day zero. For example, if there is a change to the plan of care affecting the addendum on October 17, 2026, the beneficiary should receive the addendum from the hospice no later than October 20, 2026.

Our internal target is the admission visit. Day 3 is our escalation trigger. Day 5 is the regulation’s outer limit, not a plan.

When the Clock Stops and What You Still Have to Do

Patient dies, revokes, or is discharged before the addendum is furnished	The addendum does not have to be provided. Document the reason in the medical record.
Patient dies, revokes, or is discharged after provision of form but before signing	The addendum does not have to be signed for the hospice to be paid. Document **the reason on the addendum itself**; it becomes part of the record.
Patient or representative refuses to sign	Document the reason on the addendum. A documented refusal protects the claim. An addendum that is blank does not.

There is no version of this where you do nothing.
If the addendum is missing, the reason is documented.

The 10 Required Elements: 42 CFR 418.24(c)

1. Title “Patient Notification of Hospice Non-Covered Items, Services, and Drugs”
2. Name of the hospice
3. Patient name and hospice medical record identifier
4. Terminal illness and related conditions identified
5. List of conditions and the associated items, services, and drugs we will NOT cover
6. Plain-language clinical explanation of why each is unrelated and not needed for pain or symptom management
7. References to relevant clinical practice, policy, or coverage guidelines
8. Purpose of the addendum, and the right to immediate advocacy through the BFCC-QIO
9. Name, signature, and date, with the statement that signing is receipt only, not agreement
10. The date the hospice furnished the addendum

All 10 must appear on the addendum AND on every update to it.

CMS published an updated model form:

https://www.cms.gov/files/document/model-hospice-election-statement-addendum-august-2026.pdf

What You Do on Every Admission

1. **Confirm the election**
   Election statement complete and signed, effective date documented. That date starts the 5-day clock.

2. **Assess every condition**
   All diagnoses, not just the terminal one. You cannot defend a determination on a list you never reviewed.

3. **Reconcile everything**
   Medications including Part D, DME already in the home, supplies, dialysis, specialists, scheduled procedures.

4. **Get the relatedness determination**
   Hospice physician with the IDG decides what is related. Unrelated is the exception and must be justified.

5. **Document the rationale first**
   The addendum explanation should be the plain-language version of what is already in the clinical record.

What You Do on Every Admission (cont.)

6 **Prepare the addendum**
All 10 elements. If nothing is unrelated, say so on the form—do not skip the addendum.

7 **Furnish it and explain it**
This is a conversation, not a handoff. Explain what we cover, what we do not, and what it costs them.

8 **Sign, date, or document**
Signature and date, or the documented reason it was not signed. Record the date furnished.

9 **File it with the election statement in the medical record**
Retrievable for the patient, non-hospice providers, and Medicare contractors.

10 **Log it and watch for changes**
Ensure there is a tracking system. This may be built into the EMR. Any plan-of-care change affecting a determination triggers a three-day update.

The Determination Behind the Form

Who Decides

The hospice physician with the interdisciplinary group. It is a clinical judgment about this patient that's reviewed as the patient changes, not a standing list and not a billing decision.

The Standard

Hospice covers everything reasonable and necessary for palliation and management of the terminal illness and related conditions. CMS expects virtually all care to be hospice-covered.

CMS determined these were hard to justify as "unrelated":

- Bronchodilators or oxygen when the principal diagnosis is a respiratory condition
- Wound care and pressure ulcer treatment in a chairbound or bedbound patient
- Cardiac medications when the principal diagnosis is a cardiac condition

Write the Explanation So a Family (and a Reviewer) Understands It

Weak

“Not related to terminal diagnosis.”

A conclusion, not an explanation. No clinical reasoning, no plain language, no mention of pain or symptom management, and nothing the family can act on.

Defensible

“Your hospice diagnosis is end-stage heart failure. Your glaucoma eye drops treat a long-standing eye condition that is not caused by your heart failure and is not used to manage its symptoms, so your Part D plan, not hospice, will continue to cover them. Please share this page with your eye doctor and pharmacy.”

Test every explanation: Would a MAC nurse reviewer reach the same conclusion from our clinical record alone?

What Does “In Writing” Mean?

Hard Copy

The hospice team can provide the hard copy to the patient or representative. There must be a copy for the medical record (which may be gathered by photo, etc.).

Electronic

CMS clarified (despite comments made in 2027 Final Rule) that the addendum can be provided electronically, but a hard copy must be provided if requested.

Our internal target is the admission visit.
Day three is our escalation trigger.
Day five is the regulation’s outer limit, not a plan.

How to Say It at the Bedside

"One more document, and this one is important, so I want to walk through it with you. Medicare requires us to give this to every patient now."

"Hospice covers everything related to your terminal illness and the conditions connected to it—your comfort medications, equipment, supplies, and care team. That is almost everything."

"This form lists anything our physician and team decided is not related, which means hospice will not pay for it. Right now that list is [read it, or: empty]."

"If something is on this list, you can still have it. It gets billed to your regular Medicare or your drug plan, and you may have a copay. Please show this page to your other doctors and your pharmacy."

"Your signature just says I gave this to you today. It does not mean you agree. If you disagree, you have the right to immediate advocacy. The number is right here."

Other Hot Topics CMS and Alliance Clarified Through Q&As

1. **Does the hospice have to provide the addendum to outside providers?**

A. The hospice does not have to routinely provide the election addendum form to outside providers, but should if it was requested by a provider or vendor.

2. **Does the hospice receiving a transfer need to do a new addendum?**

A. Hospices are not required to provide a new addendum to a Medicare beneficiary transferring into the hospice program. The change of the designated hospice is not considered a revocation of the election, but is a transfer. (NOTE: Ensure the addendum was compliant!)

3. **Does the hospice receiving a transfer need to do a new addendum?**

A. CMS has not provided this guidance. The National Alliance does not advise to discharge, but rather states they are seeking clarification to use the Code 77, as hospices currently do when a CTI is late.

Other Hot Topics CMS and Alliance Clarified Through Q&As (cont.)

4. What is the "reason not signed" the hospice should document if the POA does not return the form?

A. The hospice should attempt more than once, and then if no reply, may simply state that the POA or representative simply didn't reply with a signature of the addendum. It would be prudent to document attempts and that there was a conversation.

5. What if the hospice learns that the patient went to an outside provider, such as a podiatrist, and the care is not related?

A. CMS has not specifically addressed this. At this time, the Alliance recommends that hospices provide the addendum whenever they are made aware that an update to the plan of care is necessary that impacts the diagnoses, conditions, items, services, and drugs for the addendum.

Updating the Addendum During the Stay

What Triggers An Update

- A new diagnosis or condition is identified
- A medication is added or changed and a non-coverage decision is made due to the medication being unrelated
- New DME, supplies, or an outside service starts that is unrelated
- The IDG changes a relatedness determination
- Anything that changes what is on the list, whether it's added or removed
- New findings, even after the fact, that the patient has received or plans to receive an unrelated service

What You Do Within Three Days

- Update the addendum with all 10 required elements
- Provide the update in writing to the patient or representative
- Update the copy on file with the election statement
- Notify the affected non-hospice provider so billing is correct
- Ensure the team is aware and the updates are tracked

Every patient now has an addendum, so every qualifying change now generates an update.

Where This Will Break and How We Prevent It

FAILURE POINT	OUR CONTROL
Signed copy never returns to the record	Tracking log reviewed daily; admission is not closed until the signed copy is filed
Furnished on day six because of a weekend	Furnish at the admission visit; day three escalation to the clinical manager
Explanation is a conclusion, not an explanation	IDG reviews the wording; manager audits 100% of admissions for 60 days
Determination lives only on the addendum	Rationale documented in the clinical record and reflected in the plan of care
Plan-of-care change with no update	Case manager checklist at every IDG; update log
No one owns the process	One named owner, accountable end to end

Who Owns What

Admission nurse
Assess, reconcile, furnish, explain, obtain signature or document refusal, record the date furnished

Clinical manager / QAPI
Daily exception report, monthly chart audit, corrective action and re-audit

Physician + IDG
Make and document the relatedness determination; review it at every IDG and plan-of-care change

Medical records
Signed addendum filed with the election statement and retrievable on request

Case manager
Spot plan-of-care changes that affect determinations; trigger the three-day update

Billing
Flag claims missing an addendum; reconcile determinations against what is billed outside the benefit

Process owner for the addendum end to end: _____

How We Will Know It Is Working

INDICATOR	TARGET	FREQUENCY
Admissions with the addendum furnished within five days	**100%**	Daily log, monthly report
Addenda containing all 10 required elements	**100%**	Monthly audit, 10 records minimum
Addenda signed, or reason not signed documented	**100%**	Monthly
Signed addenda filed and retrievable	**100%**	Monthly
Qualifying plan-of-care changes updated within three days	**100%**	Monthly
Determinations match what is billed outside the benefit	**100%**	Quarterly

100% audit of Medicare admissions for the first 60 days.
Monthly sampling only after two consecutive months at target.

Before You Leave the Admission Visit

- [ ] Election statement complete and signed, effective date documented
- [ ] All diagnoses assessed; medications, DME, supplies, outside services reconciled
- [ ] Relatedness determination made with the physician and documented in the record
- [ ] Addendum prepared with all 10 elements, including the date furnished
- [ ] Addendum explained in plain language, and a copy left with the patient
- [ ] Signature and date obtained OR reason documented on the addendum
- [ ] Signed copy returned and filed with the election statement
- [ ] Admission entered in the tracking log

Three Things to Remember

1. **Every Medicare election gets one**
   No request required. Effective for elections on or after October 1, 2026.

2. **Five days to furnish, three days to update**
   Our target is the admission visit. Escalate on day three.

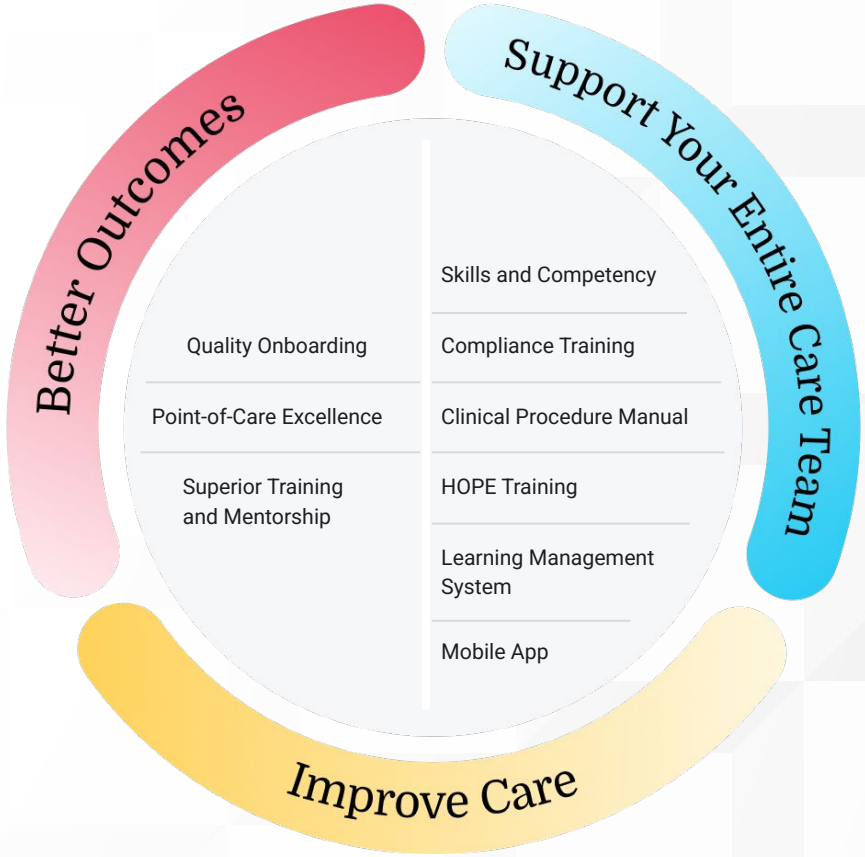
3. **Prove it, do not just do it**
   Signed, dated, filed with the election statement, and logged—or the reason documented.

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New courses and microlearning for every member of the hospice team, from aides to the IDT

May 30, 2026

Hospice Aide · 4

Aide role, personal care, and dignity-first and family support scenarios

Oct 31, 2026

HOPE Tool in Practice · 3

Section coding, J items, and IDT collaboration

HOPE Microlearning · 6

Item-level modules for Sections F, J, M, and N

Nov 30, 2026

Quality & Regulatory · 3

Hospice CAHPS, regulations, and eligibility

Star Ratings · 3

Program overview and using HOPE and CAHPS to drive performance

Jan 31, 2027

Dementia · 3

Behaviors, the 4Ms, and caregiver burnout

Medical Aid in Dying · 3

Intro plus nurse and SW/chaplain tracks

Advance Care Planning · 2

Intro and facilitating discussions

May 31, 2027

Spiritual Care Team · 5

Spiritual assessment, cultural competence, bereavement refresh, IDT care planning, and suicide risk at end of life

Just Launched: HOPE Tool in Practice Series

Every HOPE record now drives your quality scores, your public star story, and your full Medicare payment update. Three courses and item-level microlearning to strengthen HOPE data accuracy across the hospice team.

THE ISSUE

Year-One Gaps
Inconsistent coding and missed Symptom Follow-up Visits remain common sources of errors and rework.

Course 1

Capturing Sections A, F, I, M, N & Z

Section-by-section coding guidance to increase accuracy and reduce corrections.

Course 2

Accurately Capturing J Item Data

Pain and non-pain symptom impact coding and Symptom Follow-up Visit triggers.

Course 3

IDT Collaboration for Accurate Data Capture

Prepares the full interdisciplinary team to contribute to accurate, complete HOPE data.

Plus item-level microlearning for the most complex items **F** **M** **N** **J**

Questions?

Thank You